90-960

No.

In the Supreme Court of the United States

OCTOBER TERM, 1990

JAMES C. CATHEY and BETTE CATHEY,
Petitioners

V.

THE DOW CHEMICAL COMPANY MEDICAL CARE PROGRAM,
Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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QUESTIONS PRESENTED

In two related suits, one in state court and the other in federal court, James and Bette Cathey have asserted claims for health insurance benefits to pay for physician-prescribed, around the clock, skilled nursing care medically required because of Mrs. Cathey's crippling affliction, multiple sclerosis. The state courts held that all of the Catheys' claims are preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1144(a), including claims brought under provisions of the Texas Insurance Code that regulate and prohibit unfair insurance practices. Left with no state law protection, the Catheys sought relief in federal court pursuant to ERISA. The court of appeals, disregarding — indeed not even mentioning — universally accepted principles of contract construction, construed the plan so as to disallow these benefits. The result is no relief. All state law remedies are displaced, and the federal courts refuse to provide meaningful relief under ERISA. The question directly presented in this case is:

1. Can a federal court deny a claim for health care benefits under an ERISA-regulated plan that otherwise would be payable under universally accepted principles of contract interpretation, and do so *sua sponte* by adopting a construction never relied on by the Plan to justify the claim denial, without repudiating this Court's mandate to develop a federal common law of rights and obligations under ERISA-regulated plans to protect contractually defined benefits?

The importance of this issue is augmented by the complete preemption of any state law claims under statutes regulating unfair insurance practices. The state court appeal poses the following question that should be consolidated for review:

2. Can ERISA preempt a state law regulating unfair insurance practices that was enacted pursuant to the McCarran-Ferguson Act, notwithstanding the language of the "saving clause" in 29 U.S.C. § 1144(b)(2)(A) that explicitly saves from preemption "any law of any State which regulates insurance"?

LIST OF PARTIES

The names of all parties to this proceeding appear in the caption of the case.

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No. _____

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1990

JAMES C. CATHEY and BETTE CATHEY,
Petitioners

V.

THE DOW CHEMICAL COMPANY
MEDICAL CARE PROGRAM,
Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Petitioners, James C. Cathey and Bette Cathey, respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Fifth Circuit, rendered on August 3, 1990.

OPINIONS BELOW

The opinion of the Fifth Circuit Court of Appeals is reported at 907 F.2d, 554, and is reprinted in the Appendix at A-12.

The unreported findings of fact and conclusions of law, and the judgment of the United States District Court for the Southern District of Texas, Houston Division, are reprinted in the Appendix at A-29 and A-36, respectively.

The opinion of the Texas Court of Appeals in the related state court case is reported in *Cathey v. Metropolitan Life Insurance Co.*, 764 S.W.2d 286 (Tex.App.—Houston [14th Dist.] 1988, writ granted), and is reprinted in the Appendix at A-37.

The order of the Texas Supreme Court granting

review in the state court appeal is reported at 33 Tex. Sup. Ct. J. 41 (Oct. 18, 1989), and is reprinted in the Appendix at A-49 to 51.

JURISDICTION

The judgment of the United States Court of Appeals for the Fifth Circuit was signed August 3, 1990, and the timely petition for rehearing filed by the Catheys was denied on September 13, 1990. (App. A-54). The jurisdiction of this Court to review the judgment of Fifth Circuit is invoked under 28 U.S.C. § 1254.[1]

STATUTES INVOLVED

The statutory provisions involved are lengthy. Accordingly, they are reproduced in the Appendix. Their citations are as follows: (1) Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001-1461; (2) McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15; (3) Texas Insurance Code, art. 21.21 (Vernon Supp. 1990); (4) Texas Deceptive Trade Practices — Consumer Protective Act, Tex. Bus. & Com. Code Ann. § 17.50 (Vernon Supp. 1990); and (5) Texas State Board of Insurance Rules and Regulations, 28 Tex. Admin. Code §§ 21.1-.4, 21.201-.205 (West 1990).

STATEMENT OF THE CASE

A. Factual Background

James C. Cathey is a retiree from Dow Chemical Company. He and his wife, Bette Cathey, are covered by the Dow Chemical Company Medical Care Program (the Dow Program). The benefit plan is administered by Metropolitan Life Insurance Company.

Mrs. Cathey suffers from severe multiple sclerosis.

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[1] A petition for a writ of certiorari in the related state court appeal, once the Texas Supreme Court rules, will invoke this Court's jurisdiction under 28 U.S.C. § 1257.

She is incapable of engaging in the simplest chores of self-care. She is subject to seizures, which requires constant monitoring and emergency intervention. (PX-11, 13). Bette Cathey's treating physician, Dr. Raymond Torp, described her as "grossly incapacitated." (PX-22). In 1981, Dr. Torp prescribed private duty, in-home nursing services for treatment of her condition. (PX-2, 3). In his opinion, these services were medically necessary "due to severe multiple sclerosis." (PX-4). Michael Maddolin, a claims consultant with Metropolitan, initially questioned whether the nursing services were "custodial," rather than "medically necessary." (App. A-62-63; PX-5). Dr. Torp confirmed that the nursing services were indeed medically necessary, writing: "She requires around the clock nursing care for management of her condition." (PX-6).

On October 26, 1982, Bette Cathey began receiving one eight-hour shift of private duty nursing care, performed by Mrs. Vlasta Jurek, a registered nurse, pursuant to Dr. Torp's orders.[2] (PX-8; Tr. vol. 3, 17). These services continued, and claims for benefits were paid by the Dow Program, for two and one-half years from 1982 until February 6, 1985.

In September 1983, Maddolin again questioned the need for the nursing services. (PX-8, 9). Nurse Jurek responded with a description of her nursing care, which included seeing that Bette Cathey got her special diet, medications, and occupational and physical therapy as ordered by Dr. Torp. Nurse Jurek's one page summary concluded: "I assist her physically and mentally to deal with this awful disease." (PX-10). Dr. Torp's response went into more detail, stating:

> Mrs. Jurek's duties include supervision of Mrs. Cathey's medical condition in addition to implementation of the orders as prescribed by the

---

[2] One eight-hour shift of services was provided, even though around the clock services were needed, because other nurses were not available. (Tr. Vol. 3, 146-47).

> physical and occupational therapists. Also, Mrs. Cathey is subject to seizures and if these should occur, Mrs. Jurek is instructed to institute standard seizure procedures.
>
> Mrs. Jurek is also instructed to monitor Mrs. Cathey's blood pressure and administer her medication as prescribed.

(PX-11).

When Maddolin later specifically asked whether Bette Cathey's care was "custodial," Dr. Torp replied: "No! She is receiving skilled nursing care!" (PX-12). This response led Maddolin to note that it was "OK to allow" continued payment since the nursing services involved "skilled care." Dr. Torp sent a follow-up letter stating:

> The above captioned patient has been under our care for the past several years. The services of round-the-clock nurses have been recommended for Mrs. Cathey.
>
> The nurses' duties would include supervision of Mrs. Cathey's medical condition in addition to implementation of orders as prescribed by the physical and occupational therapist. Also, Mrs. Cathey is subject to seizures and if these should occur the nurses have been instructed to institute standard seizure precautions.
>
> The nurses are further instructed to monitor Mrs. Cathey's blood pressure and administer her medications as prescribed. They have been advised to communicate with us periodically by letter and by phone regarding Mrs. Cathey's progress.
>
> * * *

PX-13).

The Catheys had been covered by the "Old Plan," which covered nursing services under the provisions for

"Supplemental Benefits." The relevant provision stated:

> Many health care needs are met through services performed by, or prescribed by, a physician. When this happens, your Supplemental Benefits help to cover the expense of such services as:
>
> * * *
>
> - Registered nurses.
>
> * * *

(App. A-55; PX-15, p. 7). Under the Old Plan, coverage for these services was subject to a $50,000 lifetime maximum. (App. A-56, PX-15, p. 8)

On December 11, 1984, James Cathey elected to change to the "New Plan." (PX-14). The Summary Plan Description, which outlined coverage under both the Old Plan and the New Plan, listed among the New Plan's benefits:

> *Personal Physician*: Many health care needs are met through services performed or prescribed by a physician. When this happens, the Plan will pay 80% of the reasonable and customary charges for such services as:
>
> * * *
>
> - Registered nurses.
>
> * * *

(App. A-60; PX-15, p. 14). Except for the 80% restriction, this language was identical to the coverage provision of the Old Plan under which the Dow Program had been paying for the nursing services. A significant difference was that the New Plan had a lifetime maximum benefit of $1 million. (App. A-58; PX-15, p. 13).[3]

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3 In addition, the New Plan added the following provision:

On January 25, 1985, Maddolin recommended that payment be denied for all but three hours "attributed by Mrs. Jurek to physical, occupational and speech therapy." He admitted that "[s]killed nursing services to satisfy a medical need of the patient are covered," but added that "services by a nurse which are principally to assist with the personal needs of the patient such as preparing meals, feeding, bathing, help in getting into and out of bed, movements about the house, and companionship are not within the policy provisions." (App. A-64 to 65; PX-18). Because Maddolin did not address the other services being performed, Mr. Cathey asked Maddolin to refer to Dr. Torp's prior letters (PX-11, 13), which justified the medical need for Nurse Jurek's services. (PX-19).

On February 12, 1985, Maddolin broadened the denial, stating that Nurse Jurek was rendering "no medical treatment . . . other than custodial care." (App. A-66-67; PX-20). On that same day, Dr. Torp reaffirmed that Mrs. Cathey's condition required "around the clock nurses to provide skilled nursing care," that she was "grossly incapacitated," and that she needed the nursing services he had prescribed. (PX-22). On February 23, 1985, Mr. Cathey

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(footnote 3 continued)

> *Home Health Care*: Home health care services are those provided to a covered person in his or her home after discharge from a hospital or convalescent care facility. Typical services available through approved home health care agencies — and eligible for Plan coverage — include those of registered nurses, licensed practical nurses, home health aides, and inhalation, physical, and speech therapists. However, expenses related to servides for housekeeping or custodial care are not covered by the Plan.
>
> * * *
>
> The Plan covers 100% of the *reasonable and customary* charges for a maximum of 50 home health care visits to any covered individual in any calendar year.
>
> (App. A-59 to 60).

requested that the nursing care be reinstated and that all future claims be honored. (PX-21).

By March 26, 1985, the Catheys hired an attorney who wrote to the Dow Program seeking reinstatement of the benefits that had been provided for one shift of nursing care and commencement of around the clock nursing as prescribed by Dr. Torp. (PX-27). The Dow Program responded on May 7, 1985, by denying all benefits for in-home private duty nursing care. App. A-73; PX-30)

B. Procedural History

After exhausting all administrative appeals, the Catheys filed suit in Texas state court against Metropolitan Life Insurance Company, Dow Chemical Company, and Metropolitan's claims adjuster, Michael Maddolin. The Catheys alleged various state law causes of action, including claims for unfair insurance practices in violation of article 21.21 of the Texas Insurance Code and the Texas Deceptive Trade Practices — Consumer Protection Act. The trial court granted summary judgment against the Catheys on all claims, including the ones based on Texas insurance laws, on the grounds that all were preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1144(a).

The Texas Court of Appeals affirmed. *Cathey v. Metropolitan Life Insurance Co.*, 764 S.W.2d 286 (Tex. App.—Houston [1st Dist.] 1988, writ granted) (App. A-37). The court held that certain of the statutory claims were initially "saved" under 29 U.S.C. § 1144(b)(2)(A) as 'laws regulating insurance," but were ultimately preempted by operation of the "deemer" clause of § 1144(b)(2)(B), even though the plan entity was not a party to that suit. 764 S.W.2d at 290-92.

The Texas Supreme Court granted the Catheys' application for review on the points alleging that the lower courts erred by holding the statutory claims under the

Texas Insurance Code were preempted by ERISA.[4] The case was argued on November 29, 1989, and is still pending.

While these proceedings were taking place, the Catheys filed a separate suit in state court under ERISA, 29 U.S.C. § 1132, against the Dow Chemical Company Medical Care Program. The Catheys sought reinstatement of benefits due, a declaration of their future right to benefits, and other relief. (Tr. vol. 2, p. 318). This suit was removed to federal court, based on federal question jurisdiction. (Tr. vol. 2, 311).

The district court held the claim denial was not arbitrary and capricious. The court alternatively held that even under a *de novo* standard of review, the denial was proper. (Tr. vol. 1, 18-19). The court agreed with the Dow Program that the nursing services ordered by Bette Cathey's doctor were "primarily custodial" and were therefore excluded from coverage. (App. A-32 to 33). The district court rendered judgment against the Catheys (App. A-36), from which they appealed to the United States Court of Appeals for the Fifth Circuit.

The Fifth Circuit held that the proper standard of review was *de novo*, because the plan documents did not give the administrator discretionary authority to determine entitlement to benefits. (App. A-12). *Cathey v. Dow Chemical Co. Medical Care Program*, 907 F.2d 554, 558-60 (5th Cir. 1990). The Fifth Circuit also concluded that the district court erred by denying recovery for the portion of

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[4] Coincidentally, the Texas Supreme Court granted review in *Cathey v. Metropolitan* the same day that court decided *McClendon v. Ingersoll-Rand Co.*, 779 S.W.2d 69 (Tex. 1989), which held that ERISA did not preempt an employee's claim for wrongful termination to interfere with vesting of pension benefits. This Court granted the petition for certiorari and reversed the judgment of the Texas Supreme Court. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. ____, 1990 WL 186257 (Dec. 3, 1990).

the claims that represented medically prescribed, non-custodial in-home nursing care. 907 F.2d at 561. The Catheys thus won in the Fifth Circuit on the only issues that were argued.

The Fifth Circuit then held, however, that any recovery by the Catheys for in-home skilled nursing services was governed *exclusively* by the "Home Health Care" language of the New Plan. 907 F.2d at 561. This holding drastically reduced the benefits available to Bette Cathey. The home health care provision limits coverage of in-home nursing services to fifty visits per year. (App. A-59 to 60). The Catheys had relied on the previously quoted New Plan language covering nursing services prescribed by a physician, which was limited only by the $1 million policy limit. (App. A-60 to 61).

The Fifth Circuit's construction was one never relied on or asserted by the Dow Program, and it was inconsistent with the Dow Program's own interpretation of the plan documents. The claim denial was based on the Dow Program's view that the nursing services were excluded as "custodial," and the case was tried, decided, and appealed on that theory.[5]

The Catheys urged on rehearing that the court erred by failing to adopt and apply a "federal common law of rights and responsibilities" to construe the plan provisions, as required by this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948, 954 (1989). The Catheys urged the court to reconsider its *sua sponte* revision of the plan documents and to construe the terms by developing federal common law principles that would be consistent with universally accepted rules of contract law.

The Fifth Circuit declined, without analysis or

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5 *See* Tr. vol. 1, p. 192 (defendant's Pretrial Order); Tr. vol. 3, p. 17 (trial court states: "The question that's being decided in this case, that will be decided is whether or not your services were custodial . . ."); *id.*, at 22; *id.*, at 123, 126, 128, 131, 132 (defendant's counsel states coverage issue was whether services were custodial).

explanation, to articulate any federal common law principles that would justify or explain its holding, declined to explain its failure to develop and apply any such principles, and failed to explain its departure from established principles of contract law.

REASONS FOR GRANTING THE WRIT

I. *Overview*

This case once again confronts the Court with issues arising under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001-1461. Congress culminated years of study and effort by enacting ERISA. This Court has recognized that "ERISA was enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans,' . . . and 'to protect contractually defined benefits.' " *Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948, 955 (1988) (quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983), and *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)); *see also* 29 U.S.C. § 1001(b).

ERISA broadly preempts all state laws that "relate to" an employee benefit plan. This preemption provision is substantially qualified by the "saving clause," which exempts from preemption state laws that regulate insurance, banking, or securities. In turn, the saving clause is qualified by the "deemer clause," which effectively provides that an employee benefit plan itself, with certain exceptions, cannot be subjected to regulation by the state laws that are saved from preemption. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 733 (1985).

This case indirectly presents the question of the preemptive scope of ERISA as applied to state laws regulating unfair insurance practices and directly raises the issue of the obligation of courts to develop federal common law principles for reviewing benefit determinations under plans governed by ERISA. Both issues impact the "well-being and security of millions of employees and their dependents [who] are directly affected by these plans," and

for whose benefit ERISA was enacted. *See* 29 U.S.C. § 1001(a), (c).

The preemption question is significant because the state courts held that the Catheys had no remedy except what could be found in ERISA. When the Catheys sought their remedies under ERISA in federal court, the Fifth Circuit denied them any meaningful relief, by wholly failing to develop, articulate, or apply any federal common law principles to govern its review, and by limiting the benefits recoverable by the Catheys, based on a construction of the plan documents that could not exist under otherwise established principles of contract law. The result is a complete denial of relief; state law remedies are preempted, and a federal remedy is illusory.

Because of the relationship between these issues, the Catheys respectfully submit that this case is proper for consolidation for review with the decision of the Texas Supreme Court in *Cathey v. Metropolitan Life Ins. Co.*, 764 S.W.2d 286 (Tex. App.—Houston [1st Dist.] 1988, writ granted), when that decision is made. *See Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 722, 739 n. 15 (1985) (appeals that presented complementary, interrelated issues of ERISA preemption consolidated for review).

II. *The Fifth Circuit erred by failing to adopt and apply federal common law principles under ERISA to determine the correctness of the denial of the Catheys' claim for benefits.*

Because ERISA is so sweepingly preemptive, it is essential that the remedies ERISA provides offer meaningful protection. *See Kwatcher v. Massachusetts Serv. Employees Pension Fund*, 879 F.2d 957, 966 (1st Cir. 1989). Otherwise, all that ERISA preemption accomplishes is creation of a vacuum in which employers, plan administrators, and insurers are left unregulated and may act with impunity. Such a result is contrary to Congress's express intent in enacting ERISA.

Congress recognized the need for federal courts to

develop a body of federal common law to determine rights and liabilities under ERISA. *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n. 26 (1983). This Court has emphasized that "courts are to develop a 'federal common law of rights and obligations under ERISA-regulated plans.' " *Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948, 954 (1989) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987)).

The decision in *Firestone v. Bruch* shows how this federal common law development is supposed to work. To decide the issue of the appropriate standard of judicial review of benefit determinations by plan administrators under ERISA, the Court adopted and applied established principles of trust law, relying on its own prior common law decisions, treatises, and other secondary authorities such as the *Restatement (Second) of Trusts* (1959). One of the common law principles embraced, which is relevant to this case, was that the terms of the agreement are determined by the provisions of the instrument as interpreted in light of all the circumstances and other admissible evidence of intent. 109 S.Ct. at 955.

The Court specifically referred to common law contract principles established prior to the enactment of ERISA, stating:

> Actions challenging an employer's denial of benefits before enactment of ERISA were governed by principles of contract law. If the plan did not give the employer or administrator discretionary or final authority to construe uncertain terms, the court reviewed the employee's claim as it would have any other contract claim — by looking to the terms of the plan and other manifestations of the parties' intent.

109 S.Ct. at 955.

The Court also emphasized the Congressional intent to promote the interests of ERISA participants and their beneficiaries in employee benefit plans and to protect con-

tractually defined benefits. In light of these purposes, the Court was unwilling to adopt "a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." 109 S.Ct. at 956.

The Fifth Circuit's holding is at odds with the declaration in *Firestone* that ERISA was intended "to protect contractually defined benefits." 109 S.Ct. at 955 (quoting *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)). Contractually defined benefits can hardly be protected if courts purport to construe and apply the contract provisions involved without reference to any accepted principles of contract construction. The Fifth Circuit failed to articulate or apply any principles of contract interpretation in reaching its decision. This failure continued despite the Catheys' timely petition for rehearing calling this point to the court's attention.

Other lower courts have followed *Firestone* and have begun to develop federal common law principles under ERISA. *See Wickman v. Northwestern National Ins. Co*, 908 F.2d 1077, 1084 (1st Cir. 1990) *cert. denied*, ____ U.S. ____ (1990); *Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985, 990 (4th Cir. 1990), *cert. denied*, ____ S. Ct. ____, 1990 WL 144068 (Nov. 26, 1990); *McMillan v. Parrott*, 913 F.2d 310, 311 (6th Cir. 1990); *Arnold v. Life Ins. Co. of N. America*, 894 F.2d 1566, 1567 (11th Cir. 1990). Even the Fifth Circuit has recognized this obligation in other cases. *Degan v. Ford Motor Co.*, 869 F.2d 889, 895 (5th Cir. 1989); *Hayden v. Texas - U.S. Chemical Co.*, 681 F.2d 1053, 1057 (5th Cir. 1982); *see also Morales v. Pan American Life Ins. Co.*, 914 F.2d 83, 87 (5th cir. 1990).

Unlike the Fifth Circuit in this case, other courts have looked to state law for guidance in developing federal common law principles under ERISA. *See McMillan v. Parrott*, 913 F.2d 310, 311-12 (6th Cir. 1990); *Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d at 993; *Sargeant v. International Union of Operating Engineers, Local Union 478 Health Benefits & Ins. Fund*, 746 F. Supp. 241, 244

(D. Conn. 1990); *but see Harris v. Blue Cross & Blue Shield of Texas, Inc.*, 729 F. Supp. 49, 52 (N.D. Tex. 1990). The rationale for looking to state law approaches to interpreting insurance contracts is that state courts generally have had much more experience in the area. *Wickman*, 908 F.2d at 1084; *see also Schiller v. Mutual Benefit Life Ins. Co.*, 713 F. Supp. 1064, 1066 (E.D. Tenn. 1989).[6]

Lower courts have also resorted to treatises and other secondary authorities relevant to contract and insurance law, just as this Court did in *Firestone* with respect to trust law. *See Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 538-39 (9th Cir. 1990); *Wickman v. Northwestern National Ins. Co.*, 908 F.2d at 1085-86; *Provident Life v. Waller*, 906 F.2d at 993-94; *Kane v. Aetna Life Ins.*, 893 F.2d 1283, 1285-86 (11th Cir.) *cert. denied*, 111 S. Ct. 232 (1990).[7]

It is only logical that, with respect to insurance benefit issues, the developing federal common law "must embody common-sense canons of contract interpretation." *Wickman v. Northwestern National Ins. Co.*, 908 F.2d at 1084 (quoting *Burnham v. Guardian Life Ins. Co. of America*, 873 F.2d 486, 489 (1st Cir. 1989)). Rules of construction that have been adopted under ERISA by other courts include: giving terms their plain meanings, meanings that comport with the interpretations given by the average person, *Wickman*, 908 F.2d at 1084; *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1441 (9th Cir. 1990); *Burnham v. Guardian Life Ins.*, 873 F.2d at 490; liberal con-

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6 The alternative of ignoring principles that have been developed by the state courts "invites federal lawsuits to reconsider every issue of insurance contract interpretation that has ever been litigated in the state courts." *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1442 (9th Cir. 1990) (Schroeder, J., dissenting in part).

7 Similarly, in their petition for rehearing, the Catheys asked the court of appeals to reconsider its erroneous construction of the plan documents, in light of common law contract principles recognized in prior Fifth Circuit decisions and in authorities such as the *Restatement (Second) of Contracts* (1981).

struction in favor of the policyholder or beneficiary, and strict construction against the insurer in order to afford the protection the insured endeavored to procure, *Wickman*, 908 F.2d at 1084; construing ambiguities against the insurer as drafter of the document, *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d at 538-39[8]; *Arnold v. Life Ins. Co. of N. America*, 894 F.2d at 1570 (Johnson, J., dissenting); and an insurer may be estopped in reference to the meaning of a contract term by its own interpretation of that term, *Kane v. Aetna Life Ins.*, 893 F.2d at 1286.

Although the issue in *Firestone* was different, the analysis applies. The present case presents the question of what standards apply when deciding whether the plan provides coverage for a claim, rather than the standard for

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8 The rule of *contra proferentem*, requiring that insuring agreements be construed strictly against the drafter, was justified by the court as follows:

> . . . Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafters' expertise and experience, the insurer should be expected to set forth any limitations on its liability clearly enough for a common lay person to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence. Moreover, once the policy language has been drafted, it is not usually subject to amendment by the insured, even if he sees an ambiguity; an insurer's practice of forcing the insured to guess and hope regarding the scope of coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament. Were we to promulgate a federal rule, we would find these common-sense rationales sound. Indeed, it would take a certain degree of arrogance to controvert an opinion held with such unanimity in the various states and to adopt a contrary view as the federal rule. We hold, therefore, that the rule of *contra proferentem* applies to the case at bar, regardless of whether it applies as a matter of uniform federal law or because federal law incorporates state law on this point.

910 F.2d at 540.

reviewing the claim decision.[9] This Court in *Firestone* recognized that "the validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of the terms of the plan at issue." 109 S.Ct. at 956. This is such a case. The same type of common law principles turned to in *Firestone* and in cases following *Firestone* should have been used by the Fifth Circuit in this case. If the lower court had applied the most basic canons of contract interpretation, it could not have adopted the construction that it did. The following discussion will focus on the specific analysis employed by the court and will detail the analysis that should have been used.

For two years, from 1982 to 1984, the Dow Program paid for Nurse Jurek's daily eight-hour shift of nursing services under the Old Plan. The only provision of the Old Plan that covered private duty, bedside nursing was that which provided: "Many health care needs are met through services performed by, or prescribed by, a physician. When this happens, your Supplemental Benefits help to cover the expense of such services as: . . . Registered nurses." (App. A-55; PX-15, p. 7).

The New Plan, which the Catheys switched to in December 1984, contained a substantially identical provision, which provided: "*Personal Physician:* Many health care needs are met through services performed or prescribed by a physician. When this happens, the Plan will pay 80% of the reasonable and customary charges for such services as: . . . Registered nurses." (App. A-60; PX-15, p. 14). Except for the 80% restriction, this language was identical to the coverage provision of the Old Plan under which the Dow Program had been paying for the nursing services. A significant difference was that the New Plan had a lifetime

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9 This distinction was also made in *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 541 (9th Cir. 1990), which distinguished between standards for reviewing a plan administrator's interpretation of plan provisions, and principles of construction according to which courts and administrators alike should arrive at their interpretations.

maximum benefit of $1 million. (App. A-58; PX-15, p. 13).[10]

The Fifth Circuit wrongly held that this language under the New Plan would not cover the registered nurse services prescribed by Bette Cathey's doctor. Instead, the court declared that the additional language of the Home Health Care provision was exclusive.

The starting point is the plain language of the contract. One rule of construction is to simply give the terms their plain meanings, meanings that comport with the interpretations given by an average person. *See Wickman*, 908 F.2d at 1084; *Evans v. Safeco*, 916 F.2d at 1441; *Burnham v. Guardian Life*, 873 F.2d at 490. It is undisputed that the Dow Program paid for nursing services under the coverage provision in the Old Plan. *See* 907 F.2d at 556. The Catheys reasonably understood that the same language in the New Plan would also provide coverage. The contract must be construed in a manner that protects this reasonable expectation. *See Wickman*, 908 F.2d at 1084; *Kunin v. Benefit Trust*, 910 F.2d at 538-39, 540.

The Fifth Circuit conceded that the nursing services were covered and all claims had been paid under the Old Plan. *See* 907 F.2d at 555. This coverage was acknowledged by Metropolitan on behalf of the Dow Program in a letter dated April 7, 1982, which stated: "The Dow Chemical Medical Benefit program provides benefits towards services rendered or prescribed by a licensed physician for the treatment of a sickness or injury when such services are medically necessary." (App. A-62). Because private duty, bedside nursing was covered by this language in the Old Plan, such services necessarily must also be covered by the same language in the New Plan. The Fifth Circuit's deci-

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10 This difference explains the Catheys' decision to switch to the New Plan. Benefits under the Old Plan's $50,000 had been almost exhausted. This answers the Fifth Circuit's apparent confusion regarding the reason for the change. *See* 907 F.2d at 560.

sion is contrary to the plain language of the contract.

The Fifth Circuit's error followed from its incorrect view that the terms of the Old Plan were irrelevant when construing the terms of the New Plan. *See* 907 F.2d at 560. This suggests that there were two instruments, one for the Old Plan and one for the New Plan, but that is not the case. In fact, there was but one instrument relating to both plans.

When a court is attempting to construe a contract, the court must take into consideration the circumstances surrounding the formation of that contract. *Deauville Corp. v. Federated Department Stores, Inc.*, 756 F.2d 1183, 1193 (5th Cir. 1985) (applying Texas law); *Watkins v. Petro-Search, Inc.*, 689 F.2d 537, 538 (5th Cir. 1982) (same).[11] One of the important circumstances was that the provisions of the New Plan appeared only in the summary plan description that outlines the coverage of both the Old Plan and the New Plan. (App. A-55, 57; PX-15). When two contracts are so tied together, a court must consider them together in construing their language. *See Richland Plantation Co. v. Justiss-Mears Oil Co.*, 671 F.2d 154, 156 (5th Cir. 1982); *Lawrence v. United States*, 378 F.2d 452, 461 (5th Cir. 1967). It is necessary to consider the contracts together, because the existence of the two related contracts is one of the circumstances surrounding the making of the contract. *Richland Plantation Co.*, 671 F.2d at 156. The Fifth Circuit erred by treating the Old Plan and New Plan terms as entirely independent.

Another basic tenet of contract law that undermines the Fifth Circuit's holding is the rule that the parties' own interpretation of the contract language is considered the best evidence of what was intended and may be given con-

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11 On this legal point and others to follow the Catheys cite decisions of the Fifth Circuit to emphasize the conflict with that court's own prior common law analysis, but scores of cases from this Court, other federal courts, and state courts could be cited in support of the same undisputed principles.

trolling weight. *See, e.g., Esso Int'l, Inc. v. SS Captain John*, 443 F.2d 1144, 1151 (5th Cir. 1971); *J. M. Huber Corp. v. Denman*, 367 F.2d 104, 109 (5th Cir. 1966). The reason the parties' interpretation is so important is that the goal is always to effectuate the intent of the parties; therefore, the court must put itself in the position of the parties, must take into account the parties' understanding of the contract language, and to the extent that the parties' intent was lawful the court must give effect to that intent. *Hoyt R. Matise Co. v. Zurn*, 754 F.2d 560, 564 n. 3 (5th Cir. 1985); *City of Austin, Texas v. Decker Coal Co.*, 701 F.2d at 426; *Western Beef, Inc. v. Compton Inv. Co.*, 611 F.2d 587, 592 (5th Cir. 1980).[12] In this case, the Dow Program repeatedly paid for in-home, private duty nursing under language providing coverage for services prescribed by a physician. That course of dealing under the Old Plan establishes the interpretation that must be given to the same language under the New Plan.

In addition, when a court is trying to understand the language of a contract, the court must be guided by the subsequent conduct of the parties operating under that contract. *Esso Int'l*, 443 F.2d at 1151. In this case, after the Catheys switched to the New Plan, the Dow Program paid their claims for Nurse Jurek's services under the New Plan provision for registered nursing services prescribed by a physician, just as it had paid claims under the same language in the Old Plan. The Dow Program's subsequent conduct is consistent with the interpretation of the contract the Catheys proffer. Alternatively, the Dow Program's own interpretation of the contract estopped it to later assert that Bette Cathey's nursing services were exclusively covered by the home health care language. *See Kane v. Aetna Life Ins.*, 893 F.2d at 1286 (holding as a

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12 Similarly, a course of dealing between the parties is also important when considering their intent, *Restatement (Second) of Contract* § 223, and when a contract involves repeated instances of performance, any course of performance adopted by the parties is given great weight in determining what the contract language means. *Restatement (Second) of Contracts* § 202(4).

matter of federal common law that insurer of ERISA plan was estopped by its own interpretation of contract term).

One of the key distinctions between the "Home Health Care" and "Personal Physician" provisions of the New Plan was that, while both expressly covered nursing services, the home health care section provided coverage at 100%, limited to fifty visits per year, while the personal physician language paid charges at 80%, with no fifty visit limit. In addition, once a preset out of pocket limit was reached, coverage under the latter provision would increase to 100%. (App. A-57 to 58). This 80% versus 100% distinction between the home health care and personal physician provisions provides one of the most compelling bits of evidence of how the New Plan was actually applied and understood by the Dow Program.

The only way nursing services would be covered at 80% under the New Plan was if they were paid under the "Personal Physician" language. Plaintiff's Exhibit 26 was a letter dated March 15, 1985, *after the Catheys switched to the New Plan*, in which the Dow Program wrote to James Cathey that the nursing services that had been covered at 80% would now be covered at 100% because he had reached his limit for "maximum out-of-pocket expense." (App. A-71). The language that is referred to for "maximum out-of-pocket expense" is found in the New Plan and relates solely to coverage that is otherwise provided *at 80%*, such as the "Personal Physician" provision. (App. A-57 to 58).

If the nursing services could only be covered under the home health care language, as the Fifth Circuit held, the Dow Program would have never initially paid those services at 80%, because the home health care provision gives coverage at 100%. If the in-home nursing services referred to in the letter had been covered under the home health care language instead of the personal physician language, there would have been no occasion to increase the benefits later under the "maximum out-of-pocket expense" language.

The Dow Program's own construction that in-home nursing services were covered under the language of the New Plan relating to services prescribed by a physician is of paramount importance because the highest evidence of a party's intent is that party's own construction of his language contained in a contract. *Mapco, Inc. v. Pioneer Corp.*, 615 F.2d 297, 301 (5th Cir. 1980). Moreover, given evidence showing that both parties to the contract interpreted it to cover nursing services under the provision relating to services prescribed by a physician, that construction must prevail. *See Restatement (Second) of Contracts* § 201(1). It was improper for the Fifth Circuit to construe the language in a manner that the parties themselves had neither intended nor imagined. *Burnham v. Guardian Life*, 873 F.2d at 489. A court is restricted to the interpretation of a contract that the parties made for themselves. *Lion Oil Co. v. Gulf Oil Corp.*, 181 F.2d 731, 733 (5th Cir. 1950).

The Dow Program never expressed any intention that the home health care provision would be the exclusive source of coverage for in-home nursing services. The correct understanding and interpretation of these provisions was outlined in a letter dated May 7, 1985, from the Dow Program's in-house attorney. (App. A-73; PX-30). That letter confirmed that both provisions covered in-home nursing services, subject to different restrictions. The attorney, speaking on behalf of the Dow Program and the plan administrator, stated:

> With respect to nursing services, the certificate will reflect the Plan intent that skilled nursing services that are not custodial care, provided by a Nurse other than a Nurse who lives in one's home or who is a member of one's immediate family may be a Covered Medical Expense with the covered percentage being 80% (unless otherwise reduced or excluded by other Plan provisions). Nursing care provided through a home health care agency may be covered at

> 100% (unless otherwise reduced in accordance with the other Plan provisions).

(App. A-74; PX 30). The Dow Program consistently viewed the language under the "Personal Physician" heading of the New Plan as covering in-home nursing services prescribed by a physician, just as the same language in the Old Plan had provided such coverage. The "Home Health Care" and "Personal Physician" provisions of the New Plan are clearly alternative provisions for in-home nursing services, each with different requirements.

It is an elementary rule of contract construction that contract language is construed against the drafter, in this case the Dow Program.[13] If it was the Dow Program's intent to make the home health care provision the exclusive source of coverage for private duty, bedside nursing, the Dow Program could have chosen language that clearly expressed that intent. Instead, the Dow Program simply added the home health care provision and kept intact the other language that had a covered Bette Cathey's nursing claims for over two years under the Old Plan. Any ambiguity must be construed against the Dow Plan as drafter of the contract. *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.d at 541.

Indeed, Bette Cathey's claim was not denied on the basis that the home health care provision provided the exclusive source for in-home nursing benefits, and this case was not tried on that theory. The Dow Program's argument at trial and throughout this case was that although services could be covered under the "Personal Physician" language if the services of a registered nurse were prescribed by a physician, the services in this case were excluded because they were primarily "custodial". (Tr. Vol. 3, 8).

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[13] *See, e.g., Richland Plantation Co. v. Justiss-Mears Oil Co.*, 671 F.2d at 156; *Zapata Marine Services v. O/Y Finnlines, Ltd.*, 571 F.2d 208, 209 (5th Cir. 1978); *Restatement (Second) of Contracts* § 206. The same principle has been adopted in other ERISA cases as a rule of federal common law. *See Wickman v. Northwestern National Ins. Co.*, 908 F.2d at 1084; *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d at 538-39.

At trial, the court and the parties even discussed the difference between the "Home Health Care" provision and the "Personal Physician" language. The court asked for clarification of these provisions, and the Catheys' counsel explained that it was his understanding that the coverage under the Home Health Care language was already being provided. (Tr. vol. 3, 105-106). If the Fifth Circuit's view of the plan language was correct, that understanding should have ended the case. If Bette Cathey was already receiving fifty home health care visits per year, as stated by her counsel, under the Fifth Circuit's view of the plan language she would not be entitled to any more coverage, whether the nursing services were custodial or not.

The interpretation of the plan language as providing coverage for in-home nursing services under both provisions was never challenged by the Dow Program during the claim review process, and the Dow Program's counsel never offered at trial the interpretation the Fifth Circuit embraced. In this case, the court's opinion gives the New Plan a construction that is more favorable to the Dow Program than the Dow Program ever claimed for itself in its dealings with the Catheys. Basic considerations of contract interpretation favor the objective expressions of the parties, rather than any such judicial subjectivity. *Howell v. Union Producing Co.*, 392 F.2d 95, 114 (5th Cir. 1968). The objective manifestation of the intent of the Dow Program and the Catheys is that bedside nursing was covered under the Old Plan when prescribed by a physician and was covered under the same language of the New Plan.

The action of the court of appeals in this case establishes the principle that under ERISA contracts can be construed to deny benefits even though accepted rules of contract construction applicable under federal and state law in any other context would support recovery. The aberrant reading adopted by the Fifth Circuit "has so far departed from the accepted and usual course of judicial proceedings . . . as to call for an exercise of this Court's power of supervision." *See* Sup. Ct. R. 10. The Catheys fur-

ther submit that the judgment of the court of appeals is at odds with the legislative intent of ERISA and this Court's holdings that courts are to develop a body of federal common law principles to review benefit determinations under plans governed by ERISA in order to protect ERISA beneficiaries and participants.

III. *The state courts erred in holding the Catheys' claims under the Texas Insurance Code were preempted by ERISA.*

The question of the scope of the preemption and saving clauses is not directly at issue in this case. The Catheys' claim for benefits from the plan clearly "relates to" the plan and thus invokes the preemption clause. *Pilot Life Ins. Co. v. Dedeaux*, 107 S. Ct. 1549, 1553 (1987). Moreover, any state insurance law remedies that are "saved" could not apply to the plan itself, because of the operation of the deemer clause. *FMC Corp. v. Holliday*, 111 S. Ct. 403 (1990) (slip op. at 6). Nevertheless, the overly broad preemption holdings of the state courts have an indirect impact, because the Catheys were left with only their federal remedies under ERISA as an avenue for relief, one which the federal courts failed to give effect.

As previously discussed, the preemption language of ERISA is broad, but this Court has recognized that the preemption clause is explicitly limited by the saving clause, which preserves any state law that "regulates insurance, banking, or securities." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-40 (1985). This Court has had several opportunities to address the interplay of these provisions and has described their operation as follows:

> To summarize the pure mechanics of the provisions quoted above: If a state law 'relate[s] to . . . employee benefit plan[s],' it is preempted. § 514(a) [29 U.S.C. § 1144(a)]. The saving clause excepts from the preemption clause laws that 'regulat[e] insurance.' § 514(b)(2)(A) [§ 1144(b)(2)(A)]. The deemer clause makes clear that a state law that 'purport[s] to regulate insurance'

> cannot deem an employee benefit plan to be an insurance company. § 514(b)(2)(B) [§ 1144(b)(2)(B)].

Pilot Life Ins. Co. v. Dedeaux, 107 S. Ct. at 1552 (1987).

Although the preemption clause broadly preempts state law, the saving clause broadly preserves the states' lawmaking powers over much of the same regulation. *Metropolitan*, 471 U.S. at 739-40. The saving clause is entitled to no less weight than the preemption and deemer clauses. In fact, this Court recognized that the expansiveness of the preemption clause "gave the insurance saving clause a much more significant role, as a provision that saved an entire body of law from the sweeping general preemption clause." *Metropolitan*, 471 U.S. at 745 n. 23.

The saving clause maintains a century-old federal policy of leaving insurance regulation to the states. Initially, the view was that "[i]ssuing a policy of insurance is not a transaction of commerce." *Paul v. Virginia*, 8 Wall. 168, 183 (1869), *quoted in, Securities & Exchange Comm'n v. National Securities, Inc.*, 393 U.S. 453, 458 (1968). "Consequently, regulation of insurance transactions was thought to rest exclusively with the States." *SEC v. National Securities*, 393 U.S. at 458.

In 1944, this Court upset the traditional view by holding, in *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), that insurance transactions did affect commerce and were, therefore, subject to federal regulation. Congress reacted by passing the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, to make clear that "the continued regulation . . . by the several states of the business of insurance is in the public interest" and to preserve that regulation to the states.

The preemption issue involves the Catheys' state law claim arising under article 21.21 of the Texas Insurance Code. Texas regulates insurance practices through article 21.21 of the Texas Insurance Code, which prohibits unfair insurance practices relating to the sale of policies, competition between companies, relations between the insurers and

the insureds, and claims handling. The statute specifically provides that it was enacted pursuant to the authority preserved by Congress in the McCarran-Ferguson Act. Tex. Ins. Code Ann. art. 21.21, § 1.[14]

It is clear that the statute "regulates insurance," within the meaning of the ERISA saving clause. In *SEC v. National Securities,* this Court defined the "business of insurance" as follows:

> . . . Certainly the fixing of rates is part of this business; that is what *South-Eastern Underwriters* was all about. The selling and advertising of policies . . . and the licensing of companies and their agents . . . are also within the scope of the statute. Congress was concerned with the type of state regulation that centers around the contract of insurance, the transaction which *Paul v. Virginia* held was not "commerce." *The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement — these were the core of the "business of insurance."* Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. *But whatever the exact scope of the statutory term, it is clear where the focus was — it was on the relationship between the insurance company and the policyholder.* Statutes aimed at protecting or regulating this relationship are laws regulating

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14 The relevant portions of article 21.21 are reprinted in the Appendix at A-8. The statute broadly prohibits unfair insurance practices and incorporates prohibitions of the Texas Deceptive Trade Practices—Consumer Protection Act and rules and regulations of the Texas State Board of Insurance. Examples of the incorporated provisions are reprinted at App. A-6 and A-8. For a detailed discussion of the application of Tex. Ins. Code article 21.21, see *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129 (Tex. 1988).

the "business of insurance."

393 U.S. at 460 (emphasis added) (citations omitted). In *Metropolitan*, this Court expressly embraced this definition with respect to construing ERISA's saving clause. 471 U.S. at 743-44. Article 21.21 clearly regulates the relationship between the insurer and insured, and the enforcement of policies, and thus clearly regulates "the business of insurance."

The Texas court of appeals correctly held that article 21.21 was a law regulating insurance, within the scope of 29 U.S.C. § 1144(b)(2)(A). *Cathey v. Metropolitan*, 764 S.W.2d at 291. The problem with that court's analysis is that it held the deemer clause resulted in preemption of article 21.21, even in a suit that did not involve the plan entity. *Id.* This holding is clearly incorrect, in light of *Metropolitan v. Massachusetts* and the more recent decision in *FMC Corp. v. Holiday*, where this Court recognized that regulation of insurers is permissible by virtue of the saving clause, even though regulation of the plan itself would be prohibited by the deemer clause.

The argument is made, and some courts have held, that even though a statute may appear to regulate insurance, as article 21.21 does, it is nevertheless preempted under this Court's holding in *Pilot Life Ins. Co. v. Dedeaux*, because allowing an additional state law remedy for unfair claims handling would be inconsistent with the purpose of ERISA to establish a uniform federal remedy. *See Ramirez v. Inter-Continental Hotels*, 890 F.2d 760 (5th Cir. 1989); *McManus v. Travelers Health Network of Texas*, 724 F. Supp. 377 (W.D. Tex. 1990); *see also Kane v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 109 S. Ct 3216 (1989) (reaching same conclusion regarding California Insurance Code provisions). These cases are based on a misreading of *Pilot Life*. The Court's decision in *Pilot Life* must be read in the context of the facts at issue. That case dealt with a common law theory of general application, which was not a law regulating insurance that would be saved from preemption. 107 S. Ct. at 1555. All of

this Court's discussion regarding the need for uniformity in remedies must be read in that light.

To hold that a statute regulating insurance although explicitly saved by § 1144(b)(2)(A) is nevertheless preempted out of a concern over a congressional desire for uniformity would be to read the preemption clause so broadly as to ignore the saving clause. As this Court recently recognized:

> "[N]o legislation pursues its purposes at all costs. Deciding what competing values will or will not be sacrificed to the achievements of a particular objective is the very essence of legislative choice — and it frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law."

Pension Benefit Guaranty Corp. v. LTV Corp., 110 S. Ct. 2668, 2676 (1990). In this instance, Congress desired uniformity, as expressed by the preemption clause, but Congress itself set the limit by also enacting the saving clause. The lack of uniformity that results from saving state laws regulating insurance is a consequence Congress drafted into the statute in order to serve the countervailing interest of preserving traditional state insurance regulation.

The issue of ERISA preemption is not ripe for decision, because the Texas Supreme Court has not yet ruled. The point is raised so this Court can see the importance of the issue as a justification for granting certiorari in both this case and any petition resulting from the Texas Supreme Court's ultimate decision in the state court proceeding.

CONCLUSION

This case presents a clear, but not atypical, example of how ERISA has been perverted from its goal of protecting participants and beneficiaries. Courts have applied the preemption clause so broadly as to preempt even state laws

regulating insurance that were explicitly enacted pursuant to the McCarran-Ferguson Act, which left insurance regulation to the states. Once participants and beneficiaries are left without any state law remedies, the same courts show an inexplicable unwillingness to develop federal common law principles under ERISA to provide meaningful relief. ERISA has simply become a means for health insurers and employers to pick and choose which claims will be paid and which will be denied, without any effective regulation under either state or federal law. This is hardly what Congress intended. One judicial critic has written:

> The ERISA quicksand is fast swallowing up everything that steps in it or near it. This morass serves as the stage for a theater of the absurd.

Jordan v. Reliable Life Ins. Co., 694 F. Supp. 822, 827 (N.D. Ala. 1988). Later he added:

> There is a growing phalanx of courts expressing the fear that ERISA will continue to expand and to preempt everything in its meandering path. Only Congress or the Supreme Court can rescue us from the quicksand.

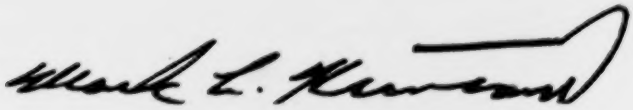
Id. at 835.

The Catheys respectfully pray that this Court will grant their petition for certiorari to clarify the obligation of courts to develop meaningful common law principles to protect participants and beneficiaries under ERISA. Petitioners further ask the Court to consider consolidating this petition with any petition for certiorari in the related state court case once the Texas Supreme Court rules on the issue of ERISA preemption of state laws regulating insurance.

The Catheys respectfully submit that their state law claims should not have been preempted, because they were based on state laws within the saving clause of ERISA, 29 U.S.C. § 1144(b)(2)(A). Moreover, even if the Catheys' rights were governed solely by ERISA, the Fifth Circuit

erred by wholly abdicating its duty to develop and apply rational principles of federal common law to construe the plan terms at issue.

Respectfully submitted,



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No. 90-960

In the Supreme Court of the United States

OCTOBER TERM, 1990

JAMES C. CATHEY and BETTE CATHEY,
Petitioners

V.

THE DOW CHEMICAL COMPANY
MEDICAL CARE PROGRAM,
Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

APPENDIX TO PETITION

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APPENDIX A

STATUTES INVOLVED

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

§ 1132. Civil enforcement.

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

* * *

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

* * *

(2)(A) Except as provided in subparagraph (B),

nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

McCARRAN-FERGUSON ACT

CHAPTER 20 - REGULATION OF INSURANCE

§ 1011. Declaration of policy

Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the

Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

§ 1012. Regulation by State Law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948.

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

TEXAS INSURANCE CODE

Art. 21.21. Unfair Competition and Unfair Practices

Declaration of purpose

Sec. 1. (a) The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress

of March 9, 1945 (Public Law 15, 79th Congress)[1], by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

(b) This Article shall be liberally construed and applied to promote its underlying purposes as set forth in this section.

* * *

Relief available to injured parties

Sec. 16. (a) Any person who has sustained actual damages as a result of another's engaging in an act or practice declared in Section 4 of this Article or in rules or regulations lawfully adopted by the Board under this Article to be unfair methods of competition or unfair or deceptive acts or practices in the business of insurance or in any practice defined by Section 17.46 of the Business & Commerce Code, as amended, as an unlawful deceptive trade practice may maintain an action against the person or persons engaging in such acts or practices.

(b) In a suit filed under this section, any plaintiff who prevails may obtain:

(1) the amount of actual damages plus court costs and reasonable and necessary attorneys' fees. If the trier of fact finds that the defendant knowingly committed the acts complained of, the court shall award, in addition, two times the amount of actual damages; or

---

[1] 15 U.S.C.A. §§ 1011 to 1015.

(2) an order enjoining such acts or failure to act; or

(3) any other relief which the court deems proper.

Texas Deceptive Trade Practices — Consumer Protection Act

Ch. 17, Texas Business & Commerce Code

Sec. 17.50. Relief for Consumers

(a) A consumer may maintain an action where any of the following constitute a producing cause of actual damages:

(1) the use or employment by any person of a false, misleading, or deceptive act or practice that is specifically enumerated in a subdivision of Subsection (b) of Section 17.46 of this subchapter;

(2) breach of an express or implied warranty;

(3) any unconscionable action or course of action by any person; or

(4) The use or employment by any person of an act or practice in violation of Article 21.21, Texas Insurance Code, as amended, or rules or regulations issued by the State Board of Insurance under Article 21.21, Texas Insurance Code, as amended.

TEXAS STATE BOARD OF INSURANCE — RULES AND REGULATIONS

28 Texas Administrative Code

§ 21.1. Deceptive Acts or Practices of Insurers, Agents, and Connected Persons

Purpose of Regulation. It is the purpose of these sections to further define and state the standards that are necessary to prohibit deceptive acts or deceptive practices by insurers and insurance agents and other persons in their conduct of the business of insurance or in connection therewith, whether done directly or indirectly, and irrespective of whether the person is acting as insurer, principal, agent, employer, or employee, or in other capacity or connection with such insurer.

* * *

§ 21.3. Unfair Trade Practices Prohibited

(a) Misrepresentation of insurance policies, unfair competition, and unfair practices by insurers, agents, and other connected persons are prohibited by Article 21.20 and Article 21.21 or by other provisions of the INSURANCE Code and by these sections of the State Board of Insurance. No person shall engage in this state in any trade practice that is a misrepresentation of an insurance policy, that is an unfair method of competition, or that is an unfair or deceptive act or practice as defined by the provisions of the Insurance Code or as defined by the sections and other rules and regulations of the State Board of Insurance authorized by the Code.

(b) Irrespective of the fact that the improper trade practice is not defined in any other section of these rules and regulations, no person shall engage in this state in any trade practice which is determined pursuant by law to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

§ 21.4. Misrepresentation Defined; Standards for Determining Misrepresentation

The term misrepresentation, or the prohibited conduct, act, or practice that constitutes misrepresentation by a person subject to the provisions of these sections, is defined as any one of the following acts or omissions:

(1) any untrue statement of a material fact; or

(2) any omission to state a material fact necessary to make the statements made (considered in the light of the circumstances under which they are made) not misleading; or

(3) the making of any statement in such manner or order as to mislead a reasonably prudent person to a false conclusion of a material fact; or

(4) any material misstatement of law; or

(5) any failure to disclose any matter required by law to be disclosed, including failure to make disclosure in accordance with the provisions of these sections and other applicable rules of the State Board of Insurance.

* * *

SUBCHAPTER 3. UNFAIR CLAIMS SETTLEMENT PRACTICES

§ 21.21. Short Title

These regulations sshall be known as the Unfair Claims Settlement Practices Rules.

* * *

§ 21.203. Unfair Claim Settlement Practice

No insurer shall engage in unfair claim settlement practices. Unfair claim settlement practice means committing or performing with such frequency as to indicate a general business practice of any of the following:

(1) Misrepresenting to claims pertinent facts or policy provisions relating to coverages at issue.

(2) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies, provided that "pertinent communications" shall exclude written communications that are direct responses to specific inquiries made by the insurer after initial report of a claim. An acknowledgement within 15 working days is presumed to be reasonably prompt.

(3) Failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies.

(4) Not attempting in good faith to efectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear;

(5) Compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

(6) Failure of any insurer to maintain a complete record of all complaints which it has received during the preceding three years or since the date of its last examination by the Commissioner of Insurance, whichever time is shorter. . . .

(7) Failing to provide promptly, when provided for in the policy, claim forms when the insurer requires such forms as a prerequisite for a claim settlement.

(8) Not attempting in good faith to settle promptly claims where liability has become reasonably clear under one portion of the policy in order to influence settlement under other portions of the policy coverage. (This provision does not apply to those situations where payment under one portion of coverage constitutes evidence of liability under another portion of coverage).

(9) Failing to provide promptly to a policyholder a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) Failing to affirm or deny coverage of a claim to a policyholder within a reasonable time after proof of loss statements have been completed. The taking of a nonwaiver agreement or the submission of a reservation of rights letter by an insurer to the policyholder

within a reasonable time is deemed compliance with the provisions of this paragraph.

(11) Except as may be specifically provided in the policy, to refuse, fail, or unreasonably delay offer of settlement under applicable first-party coverage on the basis that other coverage may be available or third parties are responsible in law for damages suffered.

(12) Attempting to settle a claim for less than the amount to which a reasonable person would have believed she/he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(13) Undertaking to enforce a full and final release from a policyholder when, in fact, only a partial payment has been made. (This provision shall not prevent or have application to the compromise settlement of doubtful or disputed claims).

(14) Failing to establish a policy and proper controls to make certain that agents calculate and deliver to policyholders or their assignees funds due under policy provisions relative to cancellation of coverage within a reasonable time after such coverages are terminated.

(15) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(16) Failing to respond promptly to a request by a claimant for personal contact about or review of the claim.

(17) With respect to the Texas personal auto policy, to delay or refuse settlement of a claim solely because there is other insurance of a different type available to satisfy partially or entirely the loss forming the basis of that claim. The claimant who has a right to recover from either or both insurers is entitled to choose under which coverage and in what order payment is to be made.

* * *

§ 21.205. Minimum standard of Performance

All insurers shall maintain their affairs so that no unfair claims settlement practices are committed and the minimum standard of performance for all insurers (as that term is used in the Insurance Code, Article 21.21-2) is to comply with the provisions of § 21.203 of this title (relating to Unfair Claims Settlement Practices).

APPENDIX B

James C. CATHEY and Bette Cathey,
Plaintiffs-Appellants,

v.

The DOW CHEMICAL COMPANY
MEDICAL CARE PROGRAM,
Defendant-Appellee.

No. 89-2971

Summary Calendar.

United States Court of Appeals,
Fifth Circuit.

Aug. 3, 1990.

Participant in health plan governed by the Employee Retirement Income Security Act (ERISA) sought reinstatement of prior home nursing benefits and declaration of rights of future benefits. The United States District Court for the Southern District of Texas, Norman W. Black, J., held that fiduciary's adverse determination of benefits was not actionable under ERISA, and participants appealed. The Court of Appeals, Jerry E. Smith, Circuit Judge held that: (1) participants were not entitled to around-the-clock home nursing benefits under terms of plan, but (2) participants were minimally entitled to 50 home nursing visits annually, if medically prescribed, and were due measure of noncustodial nursing services provided during such visits.

Affirmed in part, reversed in part, and remanded.

Joe K. Longley, Mark L. Kincaid, Longley & Maxwell, Austin, Tex., James W. Patterson, Patterson & Patterson, Houston, Tex., for plaintiffs-appellants.

A.J. Harper, II, Katherine D. Hunt, Fulbright & Jaworski, Houston, Tex., for defendant-appellee.

Appeal from the United States District Court for the Southern District of Texas.

Before HIGGINBOTHAM, SMITH, and BARKSDALE, Circuit Judges.

JERRY E. SMITH, Circuit Judge:

We undertake the painful task of denying certain medical benefits to a severely handicapped plaintiff, which were formerly available to her at home to treat her degenerative disease. However, "it is the duty of all courts of justice to take care, for the general good of the community, that hard cases do not make bad law." *United States v. Clark*, 96 U.S. 37, 49, 24 L.Ed. 696 (1877) (Harlan, J., dissenting) (quoting Lord Campbell in *East India Co. v. Paul*, 7 Moo. P.C.C. 111). Accordingly, we take particular care to ensure that our legal analysis is not influenced by the plaintiff's unfortunate health, even though the outcome may pinch the emotions.

Bette Cathey suffers from severe multiple sclerosis and is almost completely debilitated. For about two years, she elected to receive eight hours of daily home nursing care, although her physician prescribed around-the-clock nursing services. Cathey's nursing benefits, however, were terminated in 1985 by her health care provider, the Dow Chemical Medical Care Program (Dow Program), under the theory that her newly elected coverage plan excludes

"custodial" care and that the nature of her nursing services were "predominantly custodial."

Cathey and her husband, a retiree of the Dow Chemical Company (Dow), instituted this civil enforcement action under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132. They seek reinstatement of prior nursing benefits allegedly due under the Dow Program and a declaration of rights to future benefits. *See id.* § 1132(a)(1)(B). The Catheys also wish to recover damages and attorneys' fees.

The Catheys maintain that the termination of their former home medical care benefits was abusive and in contravention of the terms of the Dow Program's coverage. After a bench trial, the district court held that the fiduciary's adverse determination of benefits was not actionable under ERISA. We are asked to decide, under the appropriate standard of judicial review regarding benefit determinations, whether Cathey's nursing services are custodial and therefore excluded from coverage. We affirm in part and reverse in part.

I.

James Cathey is a retiree of Dow and a covered participant in the Dow Program, an employee welfare benefit program governed by ERISA. His wife, Bette, is a beneficiary of the same program. *See* 29 U.S.C. § 1002(8) (West Supp. 1990). Metropolitan Life Insurance Company (Metropolitan) serves as the Dow Program's designated claims fiduciary.[1]

---

[1] An ERISA fiduciary must discharge its duties with the diligence of a prudent person, in accordance with the documents and instruments governing the plan, and solely in the interests of the beneficiaries and

Bette Cathey is incapable of engaging in the simplest chores of self-care. During 1982-84, the Catheys participated in a retiree health benefit plan styled colloquially by the Dow Program as the "Old Plan." The Old Plan's benefits include private-duty bedside nursing services, at home or in a hospital, up to a total lifetime maximum of $50,000. In December 1984, however, the Catheys elected coverage under the "New Plan," offered by the Dow Program to control escalating health costs.[2]

The claims fidiciary construes the New Plan as foreclosing the home nursing care formerly enjoyed by the Catheys. The New Plan explicitly provides,

> Typical services available through approved home health care agencies—and eligible for Plan coverage—include those of registered nurses, licensed practical nurses, home health aides, and inhalation, physical, and speech therapists. *However, expenses related to services for housekeeping or custodial care are not covered by the Plan.* [Emphasis added.]

Custodial care is defined as that designed "primarily to meet personal needs and [which] could be provided by persons without professional skills or training." A physician must attest to the necessity of home nursing care, which was done repeatedly by Cathey's personal physician upon request. Significantly, under the New Plan such care is limited to a "maximum of 50 home health care visits to any covered individual in any calendar year." Accordingly around-the-clock home nursing care, even if "medically

---

Footnote 1 continued.
participants. 29 U.S.C. § 1104(a)(1); *Offutt v. Prudential Ins. Co.*, 735 F.2d 948, 950 (5th Cir. 1984).

[2] The New Plan promised lower contributions for participants but, as a tradeoff, less comprehensive coverage.

necessary," is purportedly unavailable under the New Plan; purely custodial care is excluded altogether.

In 1981, Cathey's physician, Dr. Torp, first prescribed around-the-clock home nursing to treat her progressive multiple sclerosis. In October 1982, Cathey hired a registered nurse to provide a daily eight-hour shift of private nursing care instead, while her husband remained unavailable at work. The Dow Program paid all claims presented by the Catheys, even though the claims fiduciary initially challenged the medical necessity of the home nursing care. Once Torp confirmed the medical necessity of skilled nursing care for Cathey's condition to the fiduciary's satisfaction, however, the Dow Program fully honored Cathey's nursing claims pursuant to the benefits of the Old Plan.

The fiduciary subsequently challenged Cathey's home nursing care in 1983, and again in 1984, soliciting precise identification of the registered nurse's duties from both Torp and the nurse, as well as of the time dedicated to each activity.[3] Cathey's attending nurse performed

---

[3] In November 1984, Torp responded to the fiduciary's renewed inquiry with the following letter:

> The above captioned patient has been under our care for the past several years. The services of round-the-clock [sic] nurses have been recommended for Mrs. Cathey.
>
> The nurses[sic] duties would include supervision of Mrs. Cathey's medical condition in addition to implementation of orders as prescribed by the physical and occupational therapist. Also Mrs. Cathey is subject to seizures and if these should occur the nurses have been instructed to institute standard seizure procedures.
>
> The nurses are further instructed to monitor Mrs. Cathey's blood pressure and administer her medications as

those services directed by Torp, such as administering medication, observing vital signs and bedsores, and providing emergency treatment in the event of seizure. Further, the nurse engaged in certain speech, physical, and occupational therapy and submitted written reports to Torp every four months. The fiduciary places great significance on the fact that the attending nurse also assisted Cathey in daily, mundane activities: bathing, clothing, preparing special foods, assisting Cathey in and out of bed, and serving as a companion.

Despite Torp's assertions to the contrary, the claims fiduciary concluded that the services provided by the registered nurse were in fact "primarily custodial in nature" and could be performed by an untrained attendant. The claims fiduciary initially recommended an apportionment of the daily cost of the nurse, with the Dow Program financing only the skilled portion of the services rendered (determined by the fiduciary to be three hours daily). In February 1985, however, the Dow Program selected the draconian measure of terminating Cathey's home nursing care benefits completely, on the premise that no medical treatment was being provided by the nurse and that only licensed therapists could administer to her other health needs. The Catheys have since declined to finance privately the daily nursing care.

The Dow Program notified the Catheys that their

Footnote 3 continued.

prescribed. They have been advised to communicate with us periodically by letter and by phone regarding Mrs. Cathey's progress.

The nursing services required can be administered either by a registered nurse or a licensed vocational nurse.

physician's prescribed around-the-clock home nursing could not be financed under the New Plan, freely elected by them for coverage only a few months earlier in December 1984. Instead, according to the claims fiduciary, the New Plan contemplates only fifty nursing visits per calendar year. Those visits, in addition, must provide medically necessary services and not, as alleged here, predominantly custodial services.

The Catheys exhausted their administrative remedies in seeking, minimally, reinstatement of their prior nursing benefits. Having secured no relief administratively, they commenced this ERISA suit to enforce lost benefits, secure damages and attorneys' fees, and identify future benefits owed to them pursuant to the Dow Program.

The district court upheld the fiduciary's denial of nursing benefits, concluding that the "predominant nature" of the nursing services was custodial and did not require a skilled registered nurse, despite the physician's medical appraisal to the contrary. The court admitted, however, that certain therapy exercises provided by the registered nurse here, if done by a licensed therapist instead, are covered by the New Plan. Presumably, the attending nurse failed to provide skilled therapy as contemplated by the New Plan, although the fiduciary has never challenged the nurse's qualifications generally, and no authority has been cited to us mandating such specialization for treatment.[4]

---

[4] Despite the Dow Program's self-serving assertions, we find nothing in the record or in the New Plan requiring only licensed therapists, as opposed to registered nurses, in the administration of simple physical, speech, or occupational therapy. We observe that, unless the plan mandates such specialization, courts should decline to second-guess the

The court held that the denial of home nursing services did not constitute an abuse of discretion, believed to be the appropriate standard of judicial review for benefit determinations under an ERISA-regulated plan. Alternatively, reviewing the fiduciary's determination *de novo*, the court concluded that the Dow Program engaged in a reasonable decision, consistent with the terms of the relevant instrument.

On appeal, the Catheys maintain that the appropriate standard of review for the fiduciary's denial of this claim is *de novo* review. That being so, they argue, the evidence establishes that the nursing services at issue here were not primarily—or predominantly—custodial. Specifically, the Catheys urge that incidental services provided gratuitously by the registered nurse do not operate to transform otherwise medically necessary and prescribed services into custodial services. In response, the Dow Program asserts that under either a *de novo* or abuse-of-discretion standard, the district court properly concluded that around-the-clock nursing care is not available under the New Plan and that the former nursing services at issue are entirely nonrecoverable.

II.

The appropriate standard of judicial review regarding benefit determinations by ERISA-regulated

---

Footnote 4 continued.
medical care prescribed by personal physicians, as they are most qualified to gauge the therapy needed and the likely rewards inherent in such treatment. Of course, the recoverable costs or benefits owed by the Dow Program will depend upon the degree of professional skill prescribed by the physician. That is, it may not be reasonable for a home care nurse to claim that her services are commensurate with those of licensed therapists.

fiduciaries is defined in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). The *Bruch* Court held that established principles of trust law dictate "that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* 109 S.Ct. at 956; *accord Gonzales v. Prudential Ins. Co.*, 901 F.2d 446, 449 n. 5 (5th Cir. 1990); *Barnett v. Petro-Tex Chem. Corp.* 893 F.2d 800, 808 (5th Cir. 1990), *petition for cert. denied.* ___ U.S. ___, 110 S.Ct. 3274, ___ L.Ed.2d ___ (1990).

[1,2] Accordingly, the relevant language of the ERISA-regulated health plan, if unambiguous, is reviewed *de novo* for purposes of determining the discretion retained by the plan administrator or fiduciary.[5] If the plan confers such discretionary judgment, judicial review of eligibility determinations is limited to the "abuse of discretion" standard. *Jordan v. Cameron Irons Works, Inc.*, 900 F.2d 53, 56 n. 1 (5th Cir. 1990); *Batchelor v. International Bhd. of Elec. Workers Local 861 Pension & Retirement Fund*, 877 F.2d 441, 442 (5th Cir. 1989). If, in contrast, the ERISA-governed plan does not vest discretionary authority with the plan administrator or fiduciary, or is silent regarding such author-

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[5] *Lowry v. Bankers Life & Casualty Retirement Plan*, 871 F.2d 522, 525 n. 5 (5th Cir.) (per curiam), *cert. denied*, ___ U.S. ___, 110 S.Ct. 152, 107 L.Ed.2d 111 (1989). There, we recognize that some ERISA-regulated instruments may present factual questions, and we declined to address whether federal courts are entitled, without exception, to determine the discretionary or nondiscretionary authority of ERISA fiduciaries as a matter of law. *See id.* Where, as here, the relevant plan language is unambiguous, a legal determination is merited. *Id.* We defer to a later occasion the determination of whether questions of fact concerning the discretionary nature of an ERISA plan fall within the purview of the reviewing court as well.

ity, judicial deference terminates, and eligibility determinations are reviewed *de novo*. *Bruch* 109 S.Ct. at 956; *Schultz v. Metropolitan Life Ins. Co.*, 872 F.2d 676, 678 (5th Cir. 1989).

The practical significance of *de novo* judicial review, as opposed to a more deferential standard, is that a federal court is more likely to disagree with a fiduciary's benefit determination. *Orozco v. United Air Lines, Inc.*, 887 F.2d 949, 953 (9th Cir. 1989) (per curiam). Not surprisingly, post-*Bruch* litigation has focused upon the language of ERISA-regulated plans and whether the instruments vest discretionary authority concerning entitlements with the fiduciary or administrator. Since this inquiry defines the rigor of our review, fiduciaries or administrators have argued increasingly that the instrument language expressly—or impliedly—grants to them discretionary authority over entitlements, which can be reversed only in the event such discretion is abused.

The courts of appeals that have considered, since *Bruch*, the discretion granted by ERISA instruments consistently have rejected the argument that discretionary authority can be *implied* from the instrument's language. *See, e.g., Moon v. American Home Assur. Co.*, 888 F.2d 86, 88 (11th Cir. 1989); *Orozco*, 887 F.2d at 952; *Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546, 550 (6th Cir.1989). Absent an *express* grant of discretion over entitlement determinations, the deferential review operates adversely, as the *Bruch* Court remarked, to "afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." 109 S.Ct. at 956. Accordingly, "the circuit courts which have found that particular ERISA plans granted discretion to plan administrators or fiduciaries, in cases decided after *Firestone*, have uniformly rested this finding upon *express language* of the ERISA

plan before them." *Moon*, 888 F.2d at 88 (emphasis in original).

[3] The Dow Program argues that certain portions of the New Plan's language create, "without ambiguity," discretionary decision making authority regarding entitlements.[6] We disagree. The Catheys are correct that much of the language relied upon by the Dow Program has

---

[6] The relevant "unambiguous" plan language cited by the Dow Program as conferring discretion upon the fiduciary is derived from three separate paragraphs of a document restating the terms of the Dow Program. In full context, these paragraphs provide.

> FURTHER RESOLVED, that in accordance with Sections 1 and 6 of each plan, this Board hereby delegates to *the USA Benefits Department the authority to correct any defect, supply any omission or reconcile any inconsistency in, and to control and manage* the operation and administration of *the plans.*
>
> . . . . . .
>
> *Named Fiduciary.* The Company shall be the Administrator of the Plan. Except as provided in paragraph 4, the Company shall also be the Named Fiduciary of the Plan. *The company shall have authority to control and manage the* operation and *administration of the Plan* unless and until its Board of Directors appoints a successor. The Plan Administrator may allocate responsibilities for the administration of the Plan to other persons, whether or not Named Fiduciaries, by delivering to the Company a signed written instrument specifying the nature and extent of the fiduciary responsibilities allocated and the person or persons who are designated to carry them out.
>
> . . . . . .
>
> *Benefits Claims Procedure.* The review and final decision on a claim for benefits under the insurance policy described in paragraph 2 shall be made by the insurance company that

been taken, misleadingly, out of context from three separate paragraphs in a document restating the New Plan. The first paragraph is silent with respect to the discretion reserved by the fiduciary regarding benefit determinations generally. The second paragraph recites the truism that the fiduciary shall manage the plan *until such time as a successor is appointed.* The third paragraph allocates authority (not discretion) to review claims, as between the plan administrator (Dow) and the plan fiduciary (Metropolitan). It does not, as the Dow Program suggests, expressly confer discretionary authority regarding entitlements upon the fiduciary.

Since *Bruch*, we have had several occasions to consider ERISA instruments that granted precise discretionary authority. Significantly, the express language in those instruments is unambiguous in its design to grant discretion regarding entitlements to the fiduciary or administrator. In *Lowry*, for instance, an ERISA-regulated retirement plan conferred upon the administrator the power "to determine all questions arising" in the administration of the plan, "including the power to determine the rights or eligibility of Employees and Participants and their beneficiaries, and the amounts of their respective interests." 871F.2d at 524. Further, the

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Footnote 6 continued.

> issued the policy substantially in accordance with the welfare benefit claims procedure of the [Dow Chemical] Company attached hereto and such insurance company (and *not* the Plan Administrator) shall be the "Named Fiduciary" of the Plan with regard to any review and *final decision on a claim for benefits* under such policy.

[Emphasis represents those portions cited by the Dow Program in its brief.]

administrator's determinations were held to be "binding on all persons." *Id.* We concluded in *Lowry* that the unambiguous language of the instrument "mandates deference to the plan administrators under the circumstances of this case." *Id.* at 524-25; *see also Jordan*, 900 F.2d at 55 (deference mandated because instrument expressly gives administrator broad power to determine eligibility).

Similarly, in *Batchelor* we applied deferential review to a fiduciary's determination regarding pension benefits because the instrument provided, among other things, that the fiduciary shall "have full and exclusive authority to determine all questions of coverage and eligibility." 877 F.2d at 443. The instrument language at issue here is much less precise than that in *Lowry*, *Jordan*, and *Batchelor* and, when viewed in context, is silent regarding the discretion retained by the fiduciary to make claims determinations. Accordingly, the New Plan cannot be read as granting discretion expressly, and thus we will review *de novo* the fiduciary's denial of Cathey's nursing claims here. Having the benefit of prior judicial review, however, we will not upset the district court's factual determinations unless they are clearly erroneous. Fed.R.Civ.P. 52(a); *accord Offutt*, 735 F.2d at 949.

III.

[4] The Catheys wish to restore, at a minimum, the Old Plan's home nursing benefits formerly enjoyed by them for two years. For reasons not evident from the record, they elected to substitute New Plan coverage in place of that incident to the Old Plan.[7] The conclusion is

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[7] New Plan home nursing care is, undoubtedly, less generous than that formerly provided under the Old Plan. The New Plan expressly provides,

inescapable that the Catheys made a choice that they fully regret. Indeed, they rely heavily upon the language and definitions in the former instrument as authority for the more generous nursing care purportedly owed to them now. We conclude, however, that the language of the Old Plan does not define the benefits due under the New Plan. As the Catheys have elected substitute coverage we shall adhere to their selection and review the benefits available pursuant to the instrument alone.

The district court concluded that the nursing services at issue here were predominantly custodial, which did not merit skilled care. The court also held that the New Plan completely excludes services that are predominantly custodial. We have no quarrel with the court's factual determination that the registered nurse cooked, fed, bathed, and clothed Cathey, who, all agree, cannot execute these rudimentary chores on her own. There is also no dispute that the registered nurse administered Cathey's medications, monitored her blood pressure and bedsores,

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Footnote 7 continued.

> Home Health Care: Home health care services are those provided to a covered person in his or her home after discharge from a hospital or convalescent care facility. Typical services available through approved home health care agencies—and eligible for Plan coverage—include those of registered nurses, licensed practical nurses, home health aides, and inhalation, physical, and speech therapists. *However, expenses related to services for housekeeping or custodial care are not covered by the Plan.*
>
> . . . . .
>
> *The Plan covers 100% of the reasonable and customary charges for a maximum of 50 home health care visits to any covered individual in any calendar year.* [Emphasis added.]

performed some physical and speech therapy, and observed for and treated potential seizures.

The Dow program argued, and the district court agreed, that the nurse's gratuitous household chores, such as cooking and bathing, rendered her work predominantly custodial in nature. Since the New Plan provides that "expenses related to services for housekeeping or custodial care are not covered by the Plan," recovery for such nursing care was held to be entirely unavailable.

[5] On appeal, the Catheys argue that the strict language of the New Plan does not foreclose recovery for custodial services and, alternatively, that the registered nurse's services were not primarily custodial. They suggest that an independent provision of the New Plan compensates beneficiaries for eighty percent of home nursing services. Specifically, the provision entitled "Personal Physician" maintains that "the Plan will pay 80% of the reasonable and customary charges for such services as . . . [r]egistered nurses" that are prescribed by a physician.

The Catheys invite us to interpret the instrument so as to eviscerate the separate fifty-visit "Home Health Care" restriction, holding that two separate avenues for compensation of home nursing care are available. The Catheys ignore the fact that the prescribed services outlined under the "Personal Physician" section are plainly directed at non-home medical care, such as doctor or hospital visits. The Catheys, we conclude, offer a strained interpretation of the relevant portions of the instrument, and we decline to interpret such provisions contrary to their plain meaning or in a manner rendering certain "obstructive" language inoperative.

The "Home Health Care" provision, for instance,

limits home nursing expressly to fifty home visits per year; "Personal Physician" coverage, by comparison, targets prescribed non-home medical services generally, providing eighty percent recovery for, among other things, doctor's fees, immunizations, certain medical tests, and in-patient or out-patient registered nurses. We conclude that the measure of *home nursing* benefits due under the New Plan is provided exclusively by the "Home Health Care" provision. The measure of recovery available for in-patient or out-patient nursing care is addressed elsewhere in the instrument such as under the "Personal Physician" coverage relied upon by the Catheys here.

[6] We depart with the district court, however, in its legal determination that nursing services, if predominantly custodial, foreclose recovery for home nursing care completely. Such a construction of the instrument would, as the Catheys recognize, have the perverse effect of penalizing beneficiaries and participants for gratuitous custodial services provided by attendant home nurses. We reject such an interpretation of the instrument as not being supported by its plain language.

All agree that the New Plan compensates beneficiaries and participants for non-custodial home nursing services, albeit not beyond fifty home visits annually. Further, the Catheys admit that the New Plan's home-health-care provision does not compensate home care nurses for purely gratuitous household or custodial chores. Consequently, problems arise where, as here, there is a mix of custodial and non-custodial services performed by home care nurses.

Significantly, only expenses *related to* housekeeping or custodial care are excluded by the New Plan. Accordingly, we conclude that the fiduciary is not free to reject, in

total, claims where a portion of the nursing services is noncustodial and otherwise covered by the plan. Under the instrument's language, the fiduciary remains obligated to honor those *portions* of claims that represent noncustodial home nursing care and are medically prescribed. Specifically, the fiduciary cannot reject claims outright because the home care nurse decides, as here, to serve additionally as a companion, thereby transforming the nature of the services rendered allegedly from fully recoverable into fully nonrecoverable.

By concluding that "predominantly custodial" services foreclose home nursing benefits completely, the district court had no occasion to calculate the percentage of Cathey's rejected claims, if any, representing noncustodial nursing services. We need not remand for such a calculation, as all past nursing services were honored (Private nursing costs were not incurred after termination.), and the Catheys seek only *reinstatement* of past services or, better yet, around-the-clock care.

Thus, in summary, we affirm the district court in its conclusion that the Catheys are not entitled to around-the-clock nursing benefits under the terms of the New Plan. However, they are minimally entitled to fifty home nursing visits annually, if medically prescribed, and they are due the measure of noncustodial nursing services provided during such visits. Accordingly, we AFFIRM IN PART, REVERSE IN PART, and REMAND for further proceedings consistent with this opinion.

APPENDIX C

Filed
JUL 28 1989

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JAMES C. CATHEY, JR., et ux,	§	
	§	
Plaintiffs	§	
	§	
	§	
VS.	§	CIVIL ACTION
	§	NO. H-87-732
	§	
THE DOW COMPANY MEDICAL CARE PROGRAM,	§	
	§	
	§	
Defendant.	§	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Findings of Fact

1. Plaintiffs, James C. Cathey, a retiree of The Dow Chemical Company, and his wife, Bette Cathey, brought suit against Defendant, The Dow Chemical Company Medical Care Program ("Program") under 29 U.S.C. § 1132 of the Employee Retirement Income Security Act, as amended ("ERISA"). Plaintiffs, as participants covered by a health care plan of the Program, seek recovery for the Program's denial of a claim for around-the clock, in-home skilled nursing care for Mrs. Cathey.

2. The Program is an employee welfare benefit program governed by ERISA. Pursuant to ERISA, the Program provides and internal appeals precedure for claims denial.

3. The Program was restated and adopted by the Board of Directors of The Dow Chemical Company in 1982. The Plan vests its administrators with wide discretionary authority to "correct any defect, supply any omission, reconcile any inconsistency in, and to control and manage the operation and administration of the plans."

4. The Program's designated claims fiduciary is Metropolitan Life Insurance Company. Michael Maddolin is an employee of Metropolitan who acts as a claims fiduciary the discretionary authority to "review" and render the "final decision on a claim for benefits."

5. Mrs. Cathey suffers from severe multiple sclerosis and is unable to care for herself without assistance.

6. In late 1984, the Program offered an option of two distinct health benefit plans. Plantiffs had been covered by the "Old" retiree medical care plan until December 1984, when Mrs. Cathey voluntarily opted for the "New" retiree medical care plan.

7. Beginning in late October, 1982, the Plaintiffs secured the services of a registered nurse who worked one daytime shift while Mr. Cathey was still working for The Dow Chemical Company.

8. The Program paid for the services based upon claims presented to it by Plaintiffs. In late 1983 the Program's claims consultant reviewed the skilled nursing service being performed, and it was decided to continue reim-

bursement for the nurse.

9. In late 1984, a review of the claims submitted by the Plaintiffs for the in-home services of a registered nurse was undertaken by the Program's claims administrator. After receipt of detailed descriptions of the services actually being performed by the nurse, the claim was denied on January 25, 1985.

10. Plaintiffs appealed the denial of this claim through the internal appeals process, and after review, the denial was upheld.

11. The Program, in its decision on the claim, specifically advised Plaintiffs that other services such as physical therapy and periodic visits from a registered nurse for evaluation of Mrs. Cathey's condition and reporting to her Doctor were and would be covered under the terms of the New plan. These covered services continued to be performed and were paid by the Program.

12. The material provisions of the New Plan are described in the Summary Plan Description ("SPD"):

> Care is considered "custodial" when it is primarily to meet personal needs and could be performed by persons without professional skills.
>
> * * *
>
> Home health care services are those provided to a covered person in his or her home after discharge from a hospital or convalescent care facility. Typical services available through approved home health care agencies - and eligible for Plan coverage - include those of registered nurses, licensed practical nurses, home health

> aides, and inhalation, physical, and speech therapists. However, *expenses related to services for housekeeping or custodial care are not covered by the plan.* (emphasis added)

The number of such visits are limited to fifty (50) per calendar year.

13. The claim for around-the-clock, in-home skilled nursing services for Mrs. Cathey was denied by the Program on the ground that the duties prescribed by the family doctor and being performed by the registered nurse were in fact primarily custodial in nature and could be performed by a person without professional training.

14. Mrs. Cathey's doctor testifies that the duties being performed by the registered nurse were exactly the duties he prescribed. These duties included bathing, clothing, preparing of special food, feeding, assisting her into and out of her bed and in and about the home, and being a companion to her. The nurse was to give Mrs. Cathey her medication orally, check her vital signs, observe for bedsores, and to provide relief should seizures occur. The nurse also performed various speech, physical and occupational therapy exercises with Mrs. Cathey. Reports to the doctor were to be made every four months.

15. The testimony of Plaintiffs' doctor and nurse confirmed that the predominant nature of these duties were custodial in nature and did not require a skilled, registered nurse to perform although he would prefer such person. The testimony of the nurse was that the main areas requiring judgment were the therapy exercises. These services, if performed by a professional, licensed therapist, are covered by the Program.

16. Although the type of care provided by the nurse

may be necessary for the well being of Mrs. Cathey, that does not mean that the care is covered by the terms of the Program. Here it is clear that services which are " primarily custodial" are not covered by the terms of the plan. Based upon the evidence before the Court, it is clear that the care being rendered to Mrs. Cathey by the nurse was primarily custodial within the meaning of the Program's exclusion.

17. The denial of the claim for coverage of around-the-clock, in-home skilled nursing care for Mrs. Cathey by the Program was not an abuse of the discretionary decision-making authority vested in its administrators. In addition, the decision of the Program, based upon the facts presented to it at the time the decision was made, was reasonable and consistent with the terms of the Program, as interpreted by the Court on a *de novo* review.

Conclusions of Law

Any finding of fact made which is a conclusion of law is hereby adopted as a conclusion of law. Any conclusion of law made which constitutes a finding of fact is hereby adopted as a finding of fact.

2. The challenge to a decision of a Plan to deny coverage arises under ERISA, 29 U.S.C. § 1132. Unless the plan's terms vest diversity authority in the plan's fiduciaries, review of such a decision is *de novo. Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948 (1989). If, however, upon review of the plan's terms, a court determines the plan's fiduciaries are vested with discretionary decision-making authority, review of the plan's decision is the "deferential standard" of abuse of discretion. *Lowry v. Bankers Life & Cas. Retirement Plan*, ____ F.2d ____ (5th Cir., April 28, 1989).

3. Based upon the Court's *de novo* review of The Dow Program's terms, the Court finds that wide, discretionary decision-making authority is vested in the Program's fiduciaries, including the authority to interpret the terms of the plan and to make final decisions on claims for coverage.

4. The decision of the Program's administrators to deny coverage for the in-home nursing services claims was proper and was not an abuse of discretion, based upon the information available to the Program at the time the decision was made. *Offutt v. Prudential Ins. Co. of America*, 735 F.2d 948, 950 (5th Cir. 1984); *Denton v. First Nat'l Bank of Waco*, 765 F.2d 1295, 1303-04 (5th Cir. 1985).

5. In the alternative and based upon the Court's *de novo* review of the Program's claim denial decision (based upon the evidence before the Program and the testimony and exhibits in this case), the Court finds that the decision the Program's terms.

6. In this case, there is no evidence of any bad faith or impermissible conflict of interest which would warrant any inference of improper decision making. *See Dennard v. Richards Group, Inc.*, 681 F.2d 306, 314 (5th Cir. 1982); *Lowry, supra*, slip op. p. 3299.

7. Only those expenses actually incurred by Plaintiffs for private duty registered nursing care would be recoverable had the court found the Program's decision to be arbitrary and capricious. No expenses for these services were actually incurred by the Plaintiffs after denial of coverage by the program, so no recovery for past benefits could be had, in any event. Since the Plan's decision was not arbitrary and capricious, no order requiring future coverage is warranted.

8. Costs of suit are awarded to Defendant.

Signed this 29th day of June, 1989 at Houston, Texas.

/s/ Norman W. Black
NORMAN W. BLACK
UNITED STATES DISTRICT JUDGE

APPENDIX D

Filed
JUL 3 1989

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JAMES C. CATHEY, JR., et ux,	§	
	§	
Plaintiffs	§	
	§	
	§	
VS.	§	CIVIL ACTION
	§	NO. H-87-732
	§	
THE DOW COMPANY MEDICAL CARE PROGRAM,	§	
	§	
	§	
Defendant.	§	

FINAL JUDGMENT

Pursuant to the Findings of Fact and Conclusions of Law signed this date Judgment is hereby entered for Defendant.

Signed this 29th day of June, 1989 at Houston, Texas.

/s/ Norman W. Black
NORMAN W. BLACK
UNITED STATES DISTRICT JUDGE

APPENDIX E

James C. CATHEY and Bette Cathey, Appellants,

v.

METROPOLITAN LIFE INSURANCE CO. the Dow Chemical Co., and Michael H. Maddolin, Appelles.

No. 01-88-00046-CV.

Court of Appeals of Texas, Houston (1st Dist.).

Dec. 22, 1988.

Rehearing Denied Jan. 18, 1989.

Employee and his wife brought action against employer, insurer, and insurer's employee for wrongful denial of his claim for nursing home services for care of the wife. The 113th District Court, Harris County, Geraldine B. Tennant, J., entered summary judgment in favor of defendants and employee and his wife appealed. The court of Appeals, Sam Bass, J., held that: (1) employer's insurance program was an ERISA plan; (2) common-law claims based on breach of contract, negligence, and breach of duty of fair dealing were preempted by ERISA; (3) claims under the Deceptive Trade Practices Act and the Insurance Code were preempted; (4) statutes under which plaintiffs sued were not statutes regulating insurance; and (5) preemptive effective ERISA applied to employee of plan administrator.

Affirmed.

James W. Patterson, Patterson & Patterson, Joe K. Longley, Mark L. Kincaid, Longley & Maxwell, Houston, for appellants.

A.J. Harper, II, Katherine D. Hunt, Fulbright & Jaworski, Houston, Ace Pickens, Thomas W. Bullion III, Brown, Maroney, Rose, Barber & Dye, Austin, Alvin Pasternak, Donald J. Harman, James Lenaghan, William Toppeta, New York City, for Metropolitan Life Ins. Co.

Before WARREN, STEPHANOW and SAM BASS, JJ.

OPINION

SAM BASS, Justice.

James and Bette Cathey appeal from a summary judgment in favor of Metropolitan Life Insurance Co. (met), Dow Chemical Co. (Dow), and Michawl H. Maddolin. The appellants alleged multiple common law and statutory causes of action for: (1) breach of contract under Tex.Ins.Code Ann. art. 3.62 (Vernon 1981); (2) unfair insurance practices in violation of Tex.Ins. Code Ann. art. 21.21, sec. 16 (Vernon 1981); (3) deceptive trade practices, unfair insurance practices, and unconscionable conduct in violation of Tex.Bus. & Com.Code Ann. secs. 17.46(b), and 17.50(a)(4) (Vernon 1987); as well as (4) breach of the duty of good faith and fair dealing, negligence, and gross negligence. Appellants did not assert any causes of action under the Federal Employee Retirement Income Security Act (ERISA) 29 U.S.C. § 1144 (1985).

The trial court found each cause of action was preempted by ERISA. Appellants were offered the opportunity to amend their petition to assert a cause of action under

ERISA but expressly refused to do so. The court then dismissed the suit.

We affirm.

Appellants seek recovery for wrongful denial of appellant's claim for in-home nursing services by the Dow Company Medical Care Program ("Dow Plan" or "Plan"). Because this is a summary judgment case, the facts shown by the Catheys must be taken as true. *See Nixon v. Mr. Property Management Co.*, 690 S.W.2d 546, 548-49 (Tex.1985). James Cathey was employed as a purchasing agent for Dow. During Cathey's employment, he was told by Dow representatives that he and his wife were covered by a group insurance plan. In the mid-1970's, Mrs. Cathey acquired multiple sclerosis, and eventually reached a point of disability where she could not walk without assistance. In 1982, Cathey's doctors ordered nursing care for her. These expenses were paid for under the group insurance plan carried by Met covering Dow employees. In 1985, appellee Met, acting as the claims administrator for the Dow Plan, denied certain claims for nursing care expenses under certain provisions of the Plan. Maddolin, a claims consultant for Met, evaluated the claims during his employment with Met. Dow, the Plan administrator, upheld the denial of the claims.

[1] ERISA is a pervasive regulatory scheme for "employee benefit plans." The scope of ERISA's pre-emption of state law is delineated in three sections of the statute. The "pre-emption clause" of ERISA, 29 U.S.C. § 1144(a), provides that ERISA supercedes all state laws insofar as they "relate to any employee benefit plan;" however, ERISA's "savings clause," 29 U.S.C. § 1144)b)(2)(A), excepts from the preemption clause any state law that "regulates insurance." ERISA's "deemer clause"

29 U.S.C. § 1144(b)(2)(B), provides that no employee benefit plan shall be deemed to be an insurance company for purposes of any state law purporting to regulate insurance." In sum, a state law is pre-empted if it "relate[s] to" an employee benefit plan unless it is a state law that "regulates insurance." However, a state cannot "deem" an employee benefit plan to be an insurer in order to regulate the plan under state laws regulating insurance companies.

[2-4] Appellants argue that the pre-emption provision of ERISA is not applicable because none of the defendants are an "employee benefit plan" and hence, appellants' claims do not "relate to" a "plan." We do not agree. There are three general types of "plans" regulated by ERISA: (1) an employee welfare benefit plan; (2) employee pension benefit plans; and (3) plans that are both an employee welfare benefit plan and an employee pension plan. An "employee welfare benefit plan" provides medical and other benefits in the event of sickness, accident, disability, death or unemployment. An "employee pension benefit plan" provides retirement or deferred income to employees. 29 U.S.C. § 1002(1), (2)(A), (3). The Dow Plan is an ERISA plan. ERISA applies to any employee benefit plan, fund, or program, established or maintained by any employer, to the extent such plan is "maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability. . . ." 29 U.S. C. § 1002(1). The Dow Plan is an employee welfare benefit plan since it provides medical benefits and is established and maintained by Dow, an employer engaged in commerce. 29 U.S.C. § 1003(a). Pursuant to the ERISA requirements, Dow is the designated Plan Administrator and a named fiduciary for the Plan. *See* 29 U.S.C. §§ 1002(16)(a) and 1102(a). Dow, as Plan Sponsor, has designated Met as the Plan's claims

administrator pursuant to 29 U.S.C. § 1133(2) and the regulations issued thereunder.

[5] The phrase "relate to" was given its broad common-sence meaning in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983), such that a state law "relate[s] to" a benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* The appellants' complaint alleges several state common law causes of action: breach of contract, negligence, gross negligence, and breach of the duty of good faith and fair dealing. Appellant asserts statutory causes of action of unfair insurance and deceptive trade practices under the Texas Insurance Code and the Texas Business & Commerce Code. The causes of action asserted in the appellants' complaint, each based on an alleged improper denial of a claim under an employee benefit plan, "relate to" an employee benefit plan and therefore, fall under ERISA's express pre-emption clause. *See Pilot Life Ins. Co. v. Dedeaus*, 481 U.S. 41, 107 S.Ct. 1549, 1553, 95 L.Ed.2d 39 (1987). Unless these causes of action fall under an exception in section 1144(b)(2)(A) or (B), they are expressly pre-empted.

It is well-settled that ERISA preempts state common law causes of action relating to an employee benefit plan in favor of the development of federal common law. *See Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 1549; *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987). The Supreme Court gave two reasons for rejecting the argument that the state common law of bad faith was a law regulating insurance. First, "in order to regulate insurance, a law must not just have an impact on the insurance industry, but be specifically directed toward that industry." *Id.* 107 S.Ct. at 1554. The court found that even though bad faith law is often applied to the

insurance industry, "the roots of this law are firmly planted in the general principles of [state] tort and contract law." *Id.* the law applies to any breach of contract, not just breach of an insurance contract. Second, the [state] bad faith law fails to meet the indicia of laws that relate to "the business of insurance" developed under the McCarran-Ferguson Act, 15 U.S.C. § 1011 (1984). Three criteria have been used to determine whether a practice falls under the "business of insurance" for purposes of the McCarran-Ferguson Act:

> First, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S.Ct. 3002, 3009, 73 L.Ed.2d 647 (1982) (emphasis omitted).

[6] The Cathey's complaint, with respect to its common law claims, fails for the same reasons. Their common law claims are not based on laws "specifically directed toward [the insurance] industry." The laws of negligence and breach of contract are applicabale to any tort or contract causes of action, not only those directed toward the insurance industry. For the reasons given above, we conclude that appellants' common law claims are not based on laws regulating insurance and, therefore, are pre-empted by ERISA.

This case also presents the question of whether ERISA preempts a claim for damages under the Tex.Ins.Code Ann. art. 3.62, art. 21.21, and the Tex.Bus. & Com.Code Ann. sec. 17.50(a)(4) (DTPA). *Gorman v. Life Ins. Co. of North American*, 752 S.W.2d 710 (Tex.App.—

Houston [1st Dist.] 1988, writ requested), is a case similar to the one at issue. The appellants filed suit against both Tenneco and LINA, pleading common law causes of action for: (1) breach of contract, (2) common law fraud, (3) breach of fiduciary duty, (4) breach of duty of good faith and fair dealing, and (5) negligence. Appellants also pled statutory causes of action for violations under Tex.Ins.Code Ann. art. 21.21 (Vernon Supp. 1988). The court recited that the jury found Tenneco misrepresented material facts, breached its fiduciary duty, and breached its duty of good faith and fair dealing. *See Gorman,* 752 S.W.2d at 712. From these findings, however, it is not clear that the jury found a violation of any of the statutes specifically regulating insurance, and the court did not discuss whether the causes of action under the Tex.Ins.Code and the DTPA might be saved by 29 U.S.C. § 1144(b)(2)(A).

[7,8] The Texas Legislature has declared that the purpose of art. 21.21 is "to regulate trade practices in the business of insurance." Tex.Ins.Code Ann. art. 21.21(1). Thus, art. 21.21 does not "just have an impact on the insurance industry," it is "specifically directed toward that industry." *Pilot Life,* 107 S.Ct. at 1554. Article 21.21 satisfies the U.S. Supreme Court's common-sense test for a law that "regulates insurance." *Id.* Article 21.21 also comes within the definition of a law relating to the "business of insurance" under the McCarran-Ferguson Act. *Union Labor,* 458 U.S. at 129, 102 S.Ct. at 3008. Article 21.21 regulates the terms of certain insurance contracts, and so seems to be saved from pre-emption by the savings clause as a law "which regulates insurance." Nonetheless, the language of the subsequent section of ERISA, the "deemer clause," states that an employee benefit plan shall *not* be deemed to be an insurance company "for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks,

trust companies, or investment companies." 29 U.S.C. § 1144(b)(2)(B). While a bona fide insurance company may not cease to be engaged in the business of insurance when it sells a policy to an employee benefit plan for the benefit of plan participants, *Goodrich v. General Tel. Co.*, 241 Cal. Rptr. 640, 195 Cal.App.3d 675, *review granted*, 242 Cal.Rptr. 732, 746 P.2d 871 (1987), Congress clearly did not intend employee benefit plans to be regulated under state insurance regulation laws. The deemer clause makes explicit Congress' intention to exempt from the savings clause laws regulating insurance that apply directly to benefit plans. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740-41, 105 S.Ct. 2380, 2389-90, 90, 85 L.Ed.2d 728 (1985). We hold that appellants' cause of action under art. 21.21 of the Texas Insurance Code is not protected under the "savings clause," and is therefore pre-empted by ERISA.

[9] Article 3.62 is a penalty provision of the Texas Insurance Code providing remedies for a breach of an insurance contract. Article 3.62 of the Insurance Code is titled "Penalty for Delay in Payment of Losses" and provides:

> In all cases where a loss occurs and the life insurance company, or accident insurance company . . . liable therefor shall fail to pay the same within thirty days after demand therefor, such company shall be liable to pay the holder of such policy, in addition to the amount of the loss, twelve (12%) per cent damages on the amount of such loss together with reasonable attorney fees for the prosecution and collection of such loss.

Tex.Ins.Code Ann. art. 3.62.

While art. 3.62 may be specifically directed toward the insurance industry, it cannot be said to regulate the

substantive terms of insurance contracts; it is therefore pre-empted by ERISA. *See Metropolitan Life* at 742-43, 105 S.Ct. at 2390-91. In *Juckett v. Beecham Home Improvement Prod. Inc.*, 684 F.Supp. 448 (N.D.Tex. 1988), an ERISA plan participant sued for medical expense benefits that had been denied by the claims administrator for the plan. The acting chief judge held that, based on *Pilot Life* and *Metropolitan Life*, the statutory cause of action was pre-empted by ERISA.

[10] Furthermore, the Texas Deceptive Trade Practices Act is not a law specifically designed to "regulate insurance," and therefore, causes of action under this provision are not saved from pre-emption. *See Sams v. N.L. Indus. Inc.*, 735 S.W.2d 486 (Tex.App.—Houston [1st Dist.] 1987, no writ); *Giles v. TI Employees Pension Plan*, 715 S.W.2d 58 (Tex.App.—Dallas 1986, no writ); *Felts v. Graphic Arts Employee Benefit Trust*, 680 S.W.2d 891 (Tex.App.—Houston [1st Dist.] 1984, no writ).

(11) Appellants further argue that because the ERISA plan, in this case, is insured, it is subject to indirect regulation under state law citing, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747, 105 S.Ct. 2380, 2393, 85 L.Ed.2d 728 (1987). *Metropolitan Life Ins. Co. v. Taylor*, as well as *Gorman*, all involved plans that were *fully insured*. Each decision held that the plaintiffs could not pursue remedies under state law, but were limited to pursuing remedies under ERISA.

[12,12] Appellants assert that appellees are barred from relying on the ERISA preemption as a defense since it was not affirmatively pled. Both Dow and Met pled ERISA pre-emption in their answers. Dow stated the "ERISA preempts all state law claims" in its first amended answer to the appellants' third amended petition. Met,

in its first amended answer, stated that all "state law claims of the Plaintiffs predicated upon The Dow Medical Care Program, are pre-empted by Federal Law pursuant to the terms and provisions of the Employee Retirement Income Security Act ('ERISA')." Even if appellees had not raised ERISA pre-emption in their answers, they would be permitted to do so in a motion for summary judgment. This court decided in *Gorman* that the appellees could raise ERISA pre-emption despite "their failure to raise it as an affirmative defense." *Gorman*, 752 S.W.2d at 713. The court noted that "[a] claim of federal pre-emption is a challenge to the court's subject matter jurisdiction and cannot be waived." *Id; see also International Longshoremen's Ass'n v. Davis*, 476 U.S. 380, 106 S.Ct. 1904, 90 L.Ed.2d 389 (1986); *Barry v. Dymo Graphic Sys. Inc.*, 394 Mass. 830, 478 N.E.2d 707 (1985).

[14,15] Appellants' final argument, under its first point of error, concerns the sufficiency of the affidavit of Bollinger as to the funding of the Dow employee benefit plan. Appellants assert that appellees' summary judgment proof was inadequate because the statements in the affidavit were inadmissible because they were conclusory and not founded on personal knowledge. Tex.R.Civ.P. 166a(e) states that "affidavits shall be made on personal knowledge; shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein." *Brownlee v. Brownlee*, 665 S.W.2d 222,223 (Tex.1984); Tex.R.Civ.P. 166a(e). Bollinger, the Director of the U.S. Area Benefits Department of Dow, stated that he was speaking from "personal knowledge." The affidavit expressly states that "Dow has at all times material to this suit reimbursed Met. for all monies advanced plus an expense charge thereon." The affidavit is sufficient summary judgment evidence. *See, e.g., Marek v. Tomoco Equip. Co.*,

738 S.W.2d 710, 714 (Tex.App.—Houston [14th Dis.] 1987, no writ) (in the absence of "any evidence to the contrary . . . .," a statement that the affiant "has personal knowledge of every statement contained in the affidavit . . . is sufficient to satisfy the requirements of Rule 166-A(e)); Larcon Petroleum, Inc., v. Autotronic Sys. Inc., 576 S.W.2d 873 (Tex.Civ.App.—Houston [14th Dis.] 1979, no writ) (affidavit that stated it was made on personal knowledge complied with Rule 166a(e)"). A court will not speculate whether the affiant could establish the facts contained in the affidavit if testifying from the witness stand. *A & S Elec. Contractors, Inc. v. Fischer,* 622 S.W. 2d 601, 603 (Tex.Civ.App.—Tyler 1981, no writ). The affidavit will be taken at face value. *Netherland v. Wittner,* 624 S.W.2d 685, 687-88 (Tex.App.—Houston [14th Dis.] 1981, no writ). The decision cited by appellants, *Mercer v. Daoran Corp.,* 676 S.W.2d 580 (Tex.1984), does not support their contention because that case turned on the application of the best evidence rule, which is inapplicable to the affidavit at hand.

We hold that the appellants' state common law and statutory causes of action are pre-empted by 29 U.S.C. § 1144(a), and that the trial court did not err in entering summary judgment on pre-emption grounds.

Appellants' first point of error is over-ruled.

Appellants assert, in their second point of error, that the trial court erred in granting summary judgment in favor of Maddolin. Appellee Maddolin reviewed appellants' claims in connection with his role as a consultant and employee of appellee Met. Any actions performed by Maddolin were in the course and scope of his employment for Met.

[16] For the reasons stated above, plaintiffs cannot

pursue their lawsuit againsts either Met or Dow. Any claim that they might have against Maddolin is dependent on the viability of their claim against his employer, Met. Since ERISA's pre-emptive effect applies to lawsuits asserted against a claims administrator, such as Met, it also applies to lawsuits against employees or agents of the claims administrator, such as Maddolin. *See, e.g., Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir.1987) (reach of ERISA pre-emption extends not only to the claims against CIGNA, but to claims against the insurance broker as well); *McMahon v. McDowell*, 794 F.2d 100 (3d Cir. 1986), *cert. denied*, 479 U.S. 971, 107 S.Ct. 473, 93 L.Ed.2d 417 (1987) (summary judgment in favor of corporate employer and its individual officers and directors held proper since ERISA preempts plaintiff's common law and statutory claims). Appellants herein assert state law claims against Dow, Met, and its employee Maddolin for Dow benefits. The substance of appellants' state law claims against all appellees, including Maddolin, is the same. These state law claims relate to the Dow Plan, an employee benefit plan. They are, therefore, pre-empted by ERISA, whether they are asserted against Met, against Dow, or against Maddolin. The trial court correctly granted summary judgment in favor of Maddolin.

Appellants' second point of error is overruled.

The judgment is affirmed.

APPENDIX F

ORDERS OF THE SUPREME COURT OF TEXAS
Pronounced October 18, 1989

ORDERS ON CAUSES

C-7973, PERRY MCCLENDON
v. INGERSOLL-RAND COMPANY, d/b/a INGERSOLL-RAND COMPANY; from HARRIS County; 14th district (C14-87-00768-CV, 757 SW 2d 816, 07-21-88)

The judgment of the court of appeals is reversed and the cause is remanded to the trial court

Opinion by Justice Spears
Dissenting opinion by Justice Gonzalez
Dissenting opinion by Justice Cook
joined by Chief Justice Phillips and
Justice Hecht

* * *

ORDERS ON APPLICATIONS

THE FOLLOWING APPLICATIONS FOR WRIT OF ERROR ARE GRANTED:

* * *

C-7806, PAMELA CHAMBERS GORMAN, INDIVIDUALLY AND AS ADMINISTRATRIX v. LIFE INSURANCE COMPANY OF NORTH AMERICA ET AL.; from HARRIS County; 1st district (01-86-00501-CV, 752 SW2d 710, 06-09-88) as supplemented; 2 applications

C-8323, JAMES C. CATHEY and BETTE CATHEY v. METROPOLITAN LIFE INSURANCE CO., THE DOW CHEMICAL CO., from HARRIS County; 1st district (01-88-00046-CV, 764 SW 2d 286, 12-22-88 motion for non-resident attorney to participate granted

* * *

ORDER OF COURT

THE FOLLOWING CASES ARE SET FOR SUBMISSION ON WEDNESDAY, November 29, 1989 at 9:00 a.m.:

C-7806, PAMELA CHAMBERS GORMAN, INDIVIDUALLY AND AS ADMINISTRATRIX v. LIFE INSURANCE COMPANY OF NORTH AMERICA ET AL.; from HARRIS County; 1st district (01-86-00501-CV, 752 SW2d 710, 06-09-88)

combined with

C-8323, JAMES C. CATHEY and BETTE CATHEY v. METROPOLITAN LIFE INSURANCE CO., THE DOW CHEMICAL CO., and; from HARRIS County; 1st district (01-88-0046-CV, 764 SW2d 286, 12-22-88

Total time allotted for oral argument 30-30-10 minutes

APPENDIX G

The Supreme Court of Texas
P. O. Box 12248
Capitol Station
Austin, Texas 78711
John T. Adams, Clerk

October 18, 1989

Mr. Joe K. Longley
Mr. Mark L. Kincaid
Longley & Maxwell
P. O. Box 12667
Capitol Station
Austin, TX 78711

Mr. James W. Patterson
Patterson & Patterson
1314 Texas
Houston, TX 77002

Ms. Katherine D. Hunt
Fulbright & Jaworski
1301 McKinney
Houston, TX 77010

Mr. Judson R. Wood
Vinson & Elkins
3300 First City Tower
Houston, TX 77002

Mr. Ace Pickens
Brown, Maroney, Rose, Barber & Dye
1300 One Republic Plaza
333 Guadalupe Street
Austin, TX 78701

Mr. Wiliam Toppeta
Mr. D. J. Harman/Mr. J. M. Lenaghan
Metropolitan Life Insurance Company
Law Department, One Madison Avenue
New York, NY 10001

Case Number C-8323
JAMES C. CATHEY and BETTE CATHEY vs. METROPOLITAN LIFE INSURANCE CO.,
THE DOW CHEMICAL CO., and MICHAEL H. MADDOLIN
From Harris County, First District

Counsel:

Today, the Supreme Court of Texas granted the application for writ of error in the above styled cause on the following Point/s:

Points of Error Numbers 1 and 23.

The motion of resident practicing attorney regarding admission of non-resident attorneys to participate in appeal to the Supreme Court attorneys to participate in appeal to the Supreme Court of Texas are both granted.

This cause has been set for submission and oral argument for Wednesday, November 29, 1989 at 9:00 a.m. and is consolidated for purposes of oral argument with cause number C-7806 (see enclosed letter in cause no. C-7806 for information regarding oral argument).

Please indicate on the enclosed form which attorney/s will present oral argument, (see Texas Rules of Appellate Procedure No. 172) and return the form to the Clerk's Office at your earliest convenience.

Petitioner/s hereby assessed $75.00 additional filing fee for granting the application.

Very truly yours,

JOHN T. ADAMS, Clerk

By /s/ Peggy Littlefield
Peggy Littlefield, Chief Deputy

Encl: argument form
cost bill (this letter)

APPENDIX H

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 89-2971

Filed
SEP 13 1990

JAMES C. CATHEY and
BETTE CATHEY,

Plaintiffs-Appellants,

versus

THE DOW CHEMICAL COMPANY
MEDICAL CARE PROGRAM,

Defendant-Appellee.

Appeal from the United States District Court for the
Southern District of Texas

ON PETITION FOR REHEARING
(September 13, 1990)

Before HIGGINBOTHAM, SMITH and BARKSDALE, Circuit Judges.

PER CURIAM:

IT IS ORDERED that the petition for rehearing filed in the above entitled and numbered cause be and the same is hereby DENIED.

ENTERED FOR THE COURT:

/s/ J. Smith
United States Circuit Judge

APPENDIX I

EXCERPTS FROM PLAINTIFFS' EXHIBIT 15

RETIREE MEDICAL CARE PROGRAM BROUCHURE

Medical Care Program for Retirees Under Age 65 — Old Plan:

* * *

Supplemental Benefits

What coverage do you have through Supplemental Benefits?

* * *

As with Basic Benefits, coverage applies only if the particular item of health care is medically necessary. Also, the coverage applies only to reasonable and customary charges for the care involved.

Many health care needs are met through services performed by, or prescribed by, a physician. When this happens, your Supplemental Benefits help to cover the expense of such services as:

- Doctor's office and home visits.
- Immunizations.
- Prescription drugs and medicines.
- Birth control drugs or devices fitted and prescribed by a physician.
- Registered nurses.
- Rental or purchase of some medical equipment, if Dow-approved—but rental fees cannot exceed the cost of the equipment.

- Psychotherapy treatment of a nervous or mental condition (but note the special provisions on psychotherapy treatment, outlined in a later question-and-answer).
- Orthopedic shoes having unremovable insertions or attached to a brace, when prescribed by a licensed physician and prepared by a certified orthotist prosthetist.
- Covered expenses for a stay in a hospital or convalescent care facility that foes beyond the maximum-day limit under the Basic Benefits.

* * *

What's the dollar limit on Supplemental Benefits payments?

You have a lifetime maximum of $50,000 in Supplemental Benefits for you and each of your covered dependents.

* * *

Is this the whole story on Supplemental Benefits?

Again, the answer is no. For details beyond this summary of highlights—such as specifics on coverage for services rendered in an outpatient facility for alcoholismor drug abuse—read your Certificate of Insurance or talk with the people in your local Benefits Department.

* * *

How can you get more information on this Medical Care Program

You have three sources for more details, specifics and explanations. The best sources are:

- The Certificate of Insurance.
- The group policy insurred to Dow by the Metropolitan Life Insurance Company, with all the terms and conditions of the Program.
- Your Benefits Department.

Medical Care Program for Retirees Under Age 65 — New Plan:

* * *

What's a good starting point for a basic understanding of your Medical Care Program coverage?

* * *

- The program coverage applies to necessary health care.
- *Necessary* means just that — care that's really needed. An example of health care that could involve hospital, surgical, and medical expenses without being *necessary* is plastic surgery for strictly cosmetic purposes.

* * *

Is there an out-of-pocket maximum?

Yes! Remember, the Medical Care Program is designed to protect you and your family against

serious financial hardship that could be brought on by heavy medical costs. As a shield, the Plan limits the 20% co-payment you might have to pay from your own pocket in any one calendar year for expenses covered at 80%

Above the out-of-pocket maximum, the Plan will pay 100% of the reasonable and customary charges for services normally covered at 80%, up to the maximum benefits provided by the Plan. . . .

* * *

What's the dollar limit on Plan benefits, and how does it apply?

The Medical Care Program provides you and each of your covered dependents a lifetime maximum of $1 million of total benefits from the Plan. . . .

* * *

A Summary of Coverage

After those preliminaries: What health care services of what health care provides are covered — and to what extent?

Here's your answer. It's a long one. And it's structured on a listing of health care providers and some specific medical conditions. There are lots of details. Take the time to read carefully.

* * *

Convalescent Care Facility, Inpatient: Such a

facility may be part of a hospital, or a separate institution. In either case, it serves persons who, after a hospital stay, still need medical care but not at the level a hospital provides.

For coverage by the Plan, the medical necessity of a stay in a convalescent care facility must be certified by a physician. Also, admission to the facility must be within 10 days of leaving a hospital confinement of at least three days. And, finally, the reason for the patient's continued confinement must not be "custodial."

Care is considered "custodial" when it is primarily to meet personal needs and could be provided by persons without professional skills or training.

The Plan pays 100% of the *reasonable and customary* charges for inpatient services at an approved convalescent care facility. The maximum number of days covered by the Plan depends on how many days of hospital care preceded the convalescent care. For details, check with your local Benefits Department.

* * *

Home Health Care: Home health care services are those provided to a covered person in his or her home after discharge from a hospital or convalescent care facility. Typical services available through approved home health care agencies — and eligible for Plan coverage — include those of registered nurses, licensed practical nurses, home health aides, and inhalation, physical, and speech therapists. However, expenses related to services for housekeeping or custodial care are not covered by the Plan.

Benefits are payable for home health care services when *all* the following apply:

- Arrangements for the home health care are made within 10 days of discharge from a hospital or convalescent care facility.
- A physician certifies the necessity for this care, and also the type of service, frequency and duration of treatment, and the level of professional(s) to provide the treatment.
- The required care relates directly to the condition that required the hospital or other confinement.

The Plan covers 100% of the *reasonable and customary* charges for a maximum of 50 home health care visits to any covered individual in any calendar year.

* * *

Personal Physician: Many health care needs are met through services performed or prescribed by a physician. When this happens, the Plan will pay 80% of the *reasonable and customary* charges for such services as:

- Doctor's office and home visits.
- Medical emergency room fees and related physician's fee.
- Immunizations.
- Prescription drugs and medicines.
- Birth control drugs or devices fitted and prescribed by a physician.
- Routine pap smears.
  Registered nurses.
- Rental or purchase of some medical equipment, if Dow approved — but rental fees cannot exceed the cost of the equipment.

- Orthopedic shoes having unremovable insertions or attached to a brace, when prescribed by a licensed physician and prepared by a certified orthotist prosthetist.
- Physical, occupation, or speech therapy — up to a maximum of 365 calendar days from the first date of treatment.

* * *

APPENDIX J

Michael H. Maddolin
Group Claim Consultant

Metropolitan Life
c/o Employee Benefits
Dow Houston Center
P.O. Box 42335
Houston, TX 77042

April 7, 1982

J. C. Cathey, Jr.
Box 487
Wallis, TX 77485

Re: Bette

Dear Mr. Cathey:

The Dow Chemical Medical Benefit Program provides benefits towards services rendered or prescribed by a licensed physician for the treatment of a sickness or injury when such services are medically necessary.

Services that are prescribed by a licensed physical therapist and performed by another person are not covered under the Dow Benefit Program. Services rendered for diet instructions, and that of evaluation by a social worker are also not covered under the Dow Benefit Program.

We are sorry, but based on the information that we have, at this time, there does not appear to be a medical necessity (in terms of the prevailing medical standards) involving the services rendered by the Visiting Nurse Association as there is no medical treatment being rendered other than that of custodial care. Therefore, we find it necessary to decline benefits involving services rendered by the Visiting Nurse Association.

Sincerely,

/s/ Michael H. Maddolin
Michael H. Maddolin
Group Claim Consultant

APPENDIX K

Michael H. Maddolin
Group Claim Consultant
January 25, 1985

Metropolitan Life
c/o Employee Benefits
Dow Houston Center
P.O. Box 3387
Houston, TX 77253-3387

MR. J. C. CATHEY
6027 Bowers Rd.
Wallis, TX 77485

Dear Mr. Cathey:

I have carefully reviewed Mrs. Jurek's reply to our inquiry of December 18, 1984.

Subject to further review by Metropolitan's Medical Department, it appears that only the therapy services may be eligible for continued coverage.

Skilled nursing services to satisfy a medical need of the patient are covered by the Dow group plan. However, services by a nurse which are principally to assist with the personal needs of the patient such as preparing meals, feeding, bathing, help in getting into and out of bed, movements about the house, and companionship are not within the policy provisions.

Pending final review by the Medical Department, I will advise the benefits personnel in Houston that only 3 hours attributed by Mrs. Jurek to physical, occupational and speech therapy may be covered.

Sincerely,

/s/ Michael H. Maddolin
Michael H. Maddolin
Group Claims Consultant

cc: Hugh West

APPENDIX L

Michael H. Haddolin
Group Claim Consultant

Metropolitan Life
c/o Employee Benefits
Dow Houston Center
P.O. Box 42335
Houston, TX 77042

February 12, 1985

Mr. Marvin Metcalf
Dow Chemical, U.S.A.
Benefits Department
P.O. Box 3387
Houston, TX 77235-3387

RE: REVIEW OF J.C. CATHEY NURSING EXPENSES FOR SPOUSE

Dear Marvin:

The information contained in Mrs. Cathey's claim file involving services rendered by Mrs. Jurek, R.N. has been reviewed.

Based on the information that we have, we find it necessary to advise that since there is no medical treatment being rendered other than custodial care, we must decline benefits involving services rendered by Mrs. Jurek, R.N.

Note, also, that the therapy which is being administered by Mrs. Jurek does not conform to the following guidelines and would therefore not be reimbursable:

a) Physical therapy must be prescribed by a licensed physician, deemed medically necessary for the treatment of sickness or injury, and services must be performed by a licensed physical therapist.

b) Speech therapy must be prescribed by a licensed physician, deemed medically necessary for the treatment of sickness or injury, and services must be performed by a licensed or certified speech therapist.

c) Occupational therapy must be prescribed by a licensed physican, deemed medically necessary for the treatment of sickness or injury, and services must be performed on an out-patient hospital basis by a member of the hospital staff.

If, within sixty days of the date of this letter, Mr. Cathey wishes to appeal and can provide additional information, we will be glad to review the case.

Sincerely,

/s/ Michael H. Maddolin

Michael H. Maddolin
Group Claim Consultant

pd

Plaintiff's Exhibit 20

APPENDIX M

DOW CHEMICAL U.S.A.

March 8, 1985

WILLARD H. DOW CENTER
MIDLAND, MICHIGAN 48640

Mr. James Cathey
P. O. Box 487
Wallis, TX 77485

Dear Mr. Cathey:

Enclosed is the letter from Metropolitan concerning nursing services for Mrs. Cathey. The home health aide services Mr. McArdle refers to are covered under the New Plan at 100% of the reasonable and customary cost up to a maximum of 50 visits in a calendar year for up to four (4) hours per visit, if provided through an approved home health care agency. The physical therapy services Mr. McArdle describes would be covered at 80% of the reasonable and customery charges.

I have requested that our Houston office initiate payment for the balance of the claims you submitted on 1/25/85 and 2/2/85.

Sincerely,

/s/ Hugh West

Hugh West
Employee Benefits

cc: M. Maddolin
M. Metcalf

Plaintiff's Exhibit 24

APPENDIX N

Metropolitan Life Insurance Company
c/o Employees Benefits
The Dow Chemical Company
2020 Willard H. Dow Center
Midland, Michigan 48674

Metropolitan Life
And Affiliated Companies

Frank V. McArdle
Account Consultant

March 8, 1985

Claim Identification

Employee: J.C. Cathey, Jr.
Patient: Bette

Hugh West
The Dow Chemical Company
2020 WHDC
Employee Benefits

In response to your request, we have reviewed the claim file sent to us concerning nursing services for Mrs. Cathey, commencing with a letter dated December 4, 1981 from Dr. Torp in which he indicates that the patient had been referred for VNA and Home Health Care services, up to a letter dated February 23, 1984 from Mr. Cathey seeking review of his claim for the cost of nursing care services.

The provisions of the Dow Chemical Medical Benefits Plan have been stipulated in letters from Michael Maddolin, Group Claim Consultant. In accordance with the terms of the Plan, we see no basis for coverage of full-time bedside nursing services, as full-time bedside nursing services have not been provided. Further, although Dr. Torp stipulates in his recent letter that full-time skilled nursing care is necessary, he does not describe bedside nursing services that require a graduate registered nurse to perform.

From our evaluation, however, it does seem appropriate to provide the services of a Home Health Aide to assist Mrs. Cathey with the activities of daily living, as originally prescribed by Dr. Torp, as well as a once weekly two-hour visit from VNA or other registered nurse for the purpose of checking vital signs and reporting to Dr. Torp as he wishes. It would also be appropriate to cover once weekly visits by a registered or licensed physical therapist, but we would wish to have a copy of the therapists weekly report, including a prognosis for the necessity of continued therapy, provided to Mr. Maddolin for evaluation.

We sincerely regret that this may not be coverage of all of the services which Mr. Cathey desires, but it is in accordance with the terms of the Plan.

If we can be of further service to you in this matter, please advise.

/s/ V. V. McArdle

F. V. Mc Ardle

km

PLAINTIFF'S
EXHIBIT
25

APPENDIX O

DOW CHEMICAL U.S.A.

400 WEST BELT SOUTH
P.O. Box 3387
HOUSTON, TEXAS 77001

March 15, 1985

Mr. J. C. Cathey

P.O. Box 487
Wallis, TX 77485

Dear Jim:

A provision of the New Plan which has worked in your favor is the maximum out-of-pocket expense.

If you have read the literature covering this feature, you are aware that expenses subject to 80% coverage (excluding the deductible) may be reimbursed at 100% after the amount paid by the retiree or employee reaches a certain maximum.

In your case, the maximum out of pocket is based on 2% of your annual retirement income. After age 62, the "Retirement Income" will include Social Security.

Based on Hugh West's letter of March 8, we have reconsidered all nursing expenses through February 2 under the "Maximum out-of-pocket expense" provision, and all other 1985 expenses submitted to date, and will include a makeup amount of $1097.17. The nursing charge of $600 for the week of January 28 to February 1 was detained for the final review of Metropolitan. This issue of checks will include 100% of that amount - again based on the maximum out-of-pocket provision.

Rosemary will include a copy of our review sheet which indicates all expenses processed to date in 1985 and the amounts previously paid and the makeup amounts on each expense.

Sincerely,

/s/ Marvin Metcalf

Marvin Metcalf
Benefits Manager

MM/raa

Enclosure

PLAINTIFF'S
EXHIBIT
26

APPENDIX P

DOW CHEMICAL U.S.A.

May 7, 1985WILLARD H. DOW CENTER
MIDLAND, MICHIGAN 48640

Joe K. Longley, Esq.
Longley & Maxwell
602 Brown Building
708 Colorado Street
Austin, Texas 78701

RE: J. C. CATHEY, BETTE CATHEY

Dear Mr. Longley:

I have enclosed documents in response to your request for information directed to F. V. McArdle and Marvin Metcalf. I represent The Dow Chemical Company Medical Care Program and The Dow Chemical Company as plan administrator. Metropolitan Life Insurance Company is the plan fiduciary for the payment of claims.

A booklet containing the summary plan descriptions of the retiree Medical Care Programs is enclosed. Also, I have enclosed a copy of the Medical care Program plan document, master group policy and correspondence.

The certificate of insurance for the "New Plan" is in the final stages of preparation. It should be in print within 45 days. As you know, the certificate of insurance is designed to provide more detailed information with respect to the terms of the Medical Care Program. Also, detailed information may be obtained from the Benefits Department.

With respect to nursing services, the certificate will reflect the plan intent that skilled nursing services that are not custodial care, provided by a Nurse other than a Nurse who lives in one's home or who is a member of one's immediate family may be a Covered Medical Expense with the covered percentage being 80% (unless otherwise reduced or excluded by other plan provisions). Nursing care provided through a home-health care agency may be covered at 100% (unless otherwise reduced in accordance with other plan provisions).

With respect to the claim review procedure, please refer to page 24 of your "Retiree Medical Care Program" booklet. A copy of the "Welfare Benefit Plan Claims Procedure" is enclosed as well.

If you have any questions, or concerns, please contact me at (517)636-3200. If you wish, I will provide you with a copy of the summary plan descriptions for all of the Dow benefit plans and programs for active employees as well.

Sincerely yours,

/s/ C.A. Wadsworth
C. A. Wadsworth
Attorney
Legal Department

1f/enclosures

cc: Frank McArdle
Hugh West

PLAINTIFF'S
EXHIBIT
30

APPENDIX Q

EXCERPTS FROM PLAINTIFFS' EXHIBIT 38

METROPOLITAN LIFE INSURANCE CO CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company
A Mutual Company Incorporated in New York State

The Insurance Company certifies that under and subject to the terms and conditions of Group Policy No. 11700-G issued to

THE DOW CHEMICAL COMPANY

insurance is provided for each Employee as defined in this certificate.

* * *

SUPPLEMENTAL MEDICAL EXPENSE INSURANCE

SECTION A.

BENEFIT PROVISIONS

To obtain Supplemental Medical Expense benefits, you or your Dependent must be insured when one or more of the covered medical expenses listed below are incurred during a medical expense period, and the expense or expenses must be greater than the deductible amount specified in the Hospital Expense Insurance and Surgical — Medical Expense Insurance section. It is not necessary to be confined in a hospital to be eligible for benefits.

For explanation of some of the terms used in this section, see the "Definitions" section of this coverage and of the Hospital Expense Insurance and Surgical — Medical Expense Insurance section.

Metropolitan will pay 80% of covered medical expenses which exceed the deductible amount in any medical expense period, except that

1. Benefits for any one covered person's expenses are limited to a lifetime maximum of $50,000. However, if, at any time, $1000 or more has been paid by Metropolitan for covered medical expenses for any one covered person, and you submit proof of the good health of that person to Metropolitan, the amount of benefits available to you from the date Metropolitan accepts such proof will not be reduced by the amount of benefits previously paid.

* * *

Section B.

DEFINITIONS

1. Covered Medical Expenses

"Covered Medical Expenses" means reasonable, necessary and customary charges for the types of medical services shown below. These services must be

A. performed or prescribed by a physician,

B. rendered to a covered person for the treatment of injury or sickness,

C. medically necessary in terms of prevailing medical standards.

In the case of a fee, such fee must be in accordance with the reasonable, necessary and customary range of fees, as defined in the Hospital Expense Insurance and Surgical — Medical Expense Insurance section.

The following are covered medical expenses:

* * *

private duty bedside nursing services of a registered graduate nurse at home or in a hospital, provided the nurse does not ordinarily live in your home and is not a member of your immediate family,

* * *

APPENDIX R

EXCERPT FROM DEFENDANT'S EXHIBIT 4
Listing of Group Insurance Library
relating to Nursing Services, dated March 18, 1982

* * *

NURSES

Medically necessary private duty nursing services performed by a registered nurse or licensed practical nurse are covered under the supplemental plan. If the nurse is a member of the immediate family or resides in the employee's home, charges for the nurse are not covered. Our certificate says private duty, bedside nurses, in the home or hospital are covered. But we will still cover a nurse who goes to the home to administer drugs.

We will need a statement from a physician stating that the services are medically necessary, also with the following data:

1. Reason indicating the medical necessity.

2. Services to be performed by the nurse

3. Present condition of the patient

4. Approximate length of time the nursing services will be required.

* * *

3/18/82

(3)

No. 90-960

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

JAMES C. CATHEY and BETTE CATHEY,

Petitioners

v.

THE DOW CHEMICAL COMPANY
MEDICAL CARE PROGRAM,

Respondent

RESPONSE TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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January 14, 1991

QUESTION PRESENTED

1. Did the Court of Appeals err in affirming the District Court's interpretation of the ERISA plan?

2. Does ERISA preempt state laws relating to unfair insurance claims practices?

LIST OF PARTIES

The names of all parties to this proceeding appear in the caption of the case. There are other parties in the state court action referred to by the petitioners. They are:

1. Metropolitan Life Insurance Company
2. Michael H. Maddolin
3. The Dow Chemical Company

The Dow Chemical Company Medical Care Program is not a named party in the state court action although the same issue of coverage under the Plan is involved.

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

Respondent, The Dow Chemical Company Medical Care Program ("Dow Program"), respectfully requests that this Court deny the petition for writ of *certiorari*, by which petitioners seek review of the Fifth Circuit's judgment. The opinion of the Fifth Circuit is reported at 907 F.2d 554 (5th Cir. 1990).

JURISDICTION

The Court has jurisdiction. 28 U.S.C. § 1254 (1988).

STATUTES INVOLVED

The petitioners' statement of statutes involved is correct.

STATEMENT OF THE CASE

A. Factual Background

The Dow Program is an employee welfare benefit program governed by the provisions of ERISA. As found by the District Court in its amply supported findings of fact (A-29; R. 72)[1], James C. Cathey, a retiree of The Dow Chemical Company, and his wife, Bette Cathey, brought suit against the Dow Program under 29 U.S.C. § 1132 of ERISA. The Catheys, as covered participants of the Dow Program, sought recovery for the Dow Program's denial of a claim for medical benefits, specifically around-the-clock, in-home skilled nursing care for Mrs. Cathey (A-29, No. 1; R. 72, No. 1).

In late 1984, the Dow Program offered an option of two distinct health benefit plans, referred to as the "Old" Plan and the "New" Plan (A-29, No. 6; R. 72, No. 6). The Old Plan provided a maximum lifetime benefit of $50,000, whereas the New Plan provided a maximum lifetime benefit of $1 million. Until December 1984, James Cathey and his wife were covered by the "Old" retiree medical care plan. At that time, Mr. Cathey voluntarily opted for the "New" retiree medical care plan (Tr. 96; A-30, No. 6; R. 72, No. 6). As do most medical plans, the Dow Program contains limitations on the coverage it provides, with only certain types of medical needs and care covered (A-55; DX-31).

As described in the Summary Plan Description ("SPD"), the New Plan contained restrictions and limitations on coverage—requiring that claim expenses for benefits must have been actually incurred for expenses to be covered by the plan (A-57-58; DX-31,

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[1] The record on appeal is designated "R". The trial testimony transcript is designated "Tr". Exhibits are designated "DX" for Defendant-Respondent's exhibits and "PX" for Plaintiffs-Petitioners' exhibits. The District Court's factual findings were not disturbed on appeal. The Appendix to Petition is hereafter referred to as "A".

pp. 11-12) and requiring that the expenses must be *necessary* for health care (A-57; DX-31, p. 11) to be covered. The New Plan also specified that "custodial" care is not covered. Custodial care is defined by the New Plan. It provides that:

> Care is considered 'custodial' when it is *primarily* to meet personal needs and could be provided by persons without professional skills. (Emphasis added)

(A-59; DX-31, p. 13). In addition, the New Plan contains specific provisions and limitations on "Home Health Care." Specifically, the New Plan provides:

> Typical services available through approved home health care agencies—and eligible for Plan coverage—include . . . registered nurses. . . . However, expenses related to services for housekeeping *or custodial care are not covered by the Plan.* (Emphasis added)

The number of such home health care visits is limited to a maximum of fifty per calendar year (A-60; DX-31, p. 14; A-32, No. 12; R. 72, No. 12).[2]

Mrs. Cathey suffers from severe multiple sclerosis and is unable to care for herself without assistance (Tr. 79, 82; A-30, No. 5; R. 72, No. 5). Beginning in late October 1982, the Catheys secured the services of a registered nurse who worked eight hours during the day, Monday through Friday (Tr. 17). At the time, Mr. Cathey was still working at his job for The Dow Chemical Company (Tr. 48; A-30, No. 7; R. 72, No. 7). The Dow Program paid for the services based upon claims presented to it by the Catheys (Tr. 97). In late 1983, the Dow Program's claims consultant[3]

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[2] While the Catheys' claim for around-the-clock, in-home skilled nursing care was denied under the New Plan in early 1985, coverage for home health care visits, consistent with the New Plan's terms, was expressly authorized (A-69-70; DX-27; A-68; DX-28).

[3] Metropolitan Life Insurance Company is the designated claims administrator of the Dow Program. Michael Maddolin is an employee of Metropolitan.

reviewed the nursing services being performed, and, based upon the representations of Mrs. Cathey's doctor, it was decided to continue reimbursement for the nurse's services (DX-16; A-30-31, No. 8; R. 72, No. 8).

In late 1984, a routine review of the claims submitted by the Catheys for the in-home services of a registered nurse was undertaken by the Dow Program's claims administrator. After receipt of detailed descriptions of the services actually being performed by the nurse, the claim was denied on January 25, 1985 (Tr. 98, 101-103; A-64-65; DX-20; A-31, No. 9; R. 72, No. 9). The Dow Program denied the claim for around-the-clock, in-home nursing care for Mrs. Cathey because the duties prescribed and being performed by the registered nurse were not medically necessary, were primarily custodial in nature and could be performed by a person without professional training (Tr. 29, 30, 40-41, 42, 45, 53, 75-78, 84; A-32, No. 13; R. 72, No. 13).[4] The testimony of Mrs. Cathey's doctor confirmed that the predominant nature of these services were custodial in nature and that the services did not require a registered nurse to provide them (Tr. 75-78).

The Catheys appealed the decision through the internal appeals procedure (DX-21; DX-25). Upon review of the services actually performed by the nurse and consultation with another doctor (DX-22), the Dow Program affirmed its initial decision (A-69-70; DX-27; A-68; DX-28).

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[4] Mrs. Cathey's doctor testified that the duties being performed by the registered nurse were exactly the duties he prescribed. These duties included giving oral medication, checking vital signs, observing for bedsores, watching for seizures, bathing, clothing, preparing of special food, feeding, assisting her into and out of her bed and in and about the home, and being a companion to her (Tr. 27, 40-42, 45-46, 53). The nurse also performed various speech, physical and occupational therapy exercises with Mrs. Cathey (Tr. 25, 29, 42-44, 76). Reports to the doctor were to be made every four months (Tr. 33, 46, 88; A-32, No. 14; R. 72, No. 14).

The Dow Program, in its decision on the claim, specifically advised the Catheys that other services, such as physical therapy and periodic visits from a registered nurse for evaluation of Mrs. Cathey's condition and reporting to her doctor, were and would be covered consistent with the terms of the New Plan (A-69-70; DX-27; A-68; DX-28). These covered services continued to be performed, and the charges were paid by the Dow Program (DX-39; A-31, No. 11; R. 72, No. 11).

The trial court concluded that custodial care such as that provided by the nurse may, indeed, be necessary for the well being of a patient. However, this fact does not mean that the care is covered by the terms of the Dow Program. The trial court found that it was clear that the services were "primarily custodial" and were not covered by the terms of the Plan (A-32, A-33, No. 16; R. 72, No. 16).

B. Procedural History

The Court of Appeals, after considering the trial court's findings of fact and interpretations of the Plan, which were made following a full trial on the merits, affirmed that the Plan was not required to provide around-the-clock skilled nursing care. The case was reversed and remanded in part, since all parties agreed that petitioners would be entitled to benefits for non-custodial nursing services under the "Home Health Care" portion of the Plan and that the performance of some custodial functions during such visits would not eliminate coverage of the medically necessary services. 907 F.2d at 560-562; (A-24-28).

In its decision, the Fifth Circuit provided petitioners the type of judicial review that they now seek in this Court. The Fifth Circuit accepted petitioners' argument that the claims denial decision should be reviewed *de novo*, and the Court considered the claims decision in accordance with its view of the "plain meaning" of the Plan's terms and "without deferring to either party's

interpretation . . . ", as required by this Court's holding in *Firestone Tire & Rubber Co. v. Bruch*, 109 S. Ct. 948, 955, ____ U.S. ____ (1989).

Petitioners simply disagree with the result reached by the Fifth Circuit. If disagreement with a properly decided contract dispute were a basis for review by this Court, every question of contract interpretation would ultimately lie at this Court's doors. Such a result is neither required nor permitted.

REASONS FOR DENYING THE PETITION

I. THIS IS A CASE OF ORDINARY CONTRACT INTERPRETATION RAISING NO SPECIAL OR IMPORTANT ISSUES

Supreme Court Rule 10.1 provides that a review on the discretionary writ of certiorari will be granted "*only* when there are special and important reasons therefor . . . " (Emphasis added). Acceptable reasons for the extraordinary grant of a writ of certiorari include conflicting decisions of the United States Court of Appeals on the matter; a federal question conflict between a decision of a federal Court of Appeals and State Court of last resort; a conflict with an applicable decision of this Court; or a decision that "has so far departed from the acceptable and usual course of judicial proceedings, or a sanction of such a departure by a lower court, as to call for an exercise of this Court's power of supervision". U.S. Sup. Ct. Rule 10.1.

Petitioners argue that the Fifth Circuit "so far depart[ed] from the accepted and usual course of judicial proceedings . . . " that the Court should grant certiorari (Petition at 23-24). In essence, petitioners want this Court to review the decision simply because they failed to convince the Fifth Circuit and the District Court on the merits of the ERISA claim. This Court long has been

> consistent in not granting the writ of certiorari except in cases involving principles the settlement of which is of importance to the public as distinguished from that of the par-

> ties, and in cases where there is a real and embarrassing conflict of opinion and authority between the circuit courts of appeal.

Lane v. Bowler Corp., 261 U.S. 387, 393 (1923). In effect, petitioners are asking this Court to accept this case in order to reverse "factual determinations in which the district court and the court of appeals have concurred . . . ", a practice in which this Court does not engage. *Branti v. Finkel*, 445 U.S. 507, 512 n.6 (1979); *see also National Labor Relations Board v. Hendricks County Rural Electric Corp.*, 454 U.S. 170, 176 n.8 (1981) (Cross-petition for certiorari dismissed as improvidently granted because it presented "primarily . . . a question of fact, which does not merit Court review . . .")

The crux of the petitioners' position is that the Fifth Circuit's decision ignored the "elementary rule of contract construction that contract language is construed against the drafter . . ." (Petition at 22) and violated the proper "construction of the contract that the parties made for themselves . . ." (Petition at 21). This argument fails.

A. The Court of Appeals followed the proper rules in interpreting the Plan's Provisions.

The Fifth Circuit followed standard rules of contract interpretation in construing the Plan provisions, utilizing *de novo* review, made "without deferring to either party's interpretation." *Firestone Tire & Rubber Co. v. Bruch*, 107 S. Ct. 948, 955, _____ U.S. _____ (1989). The Fifth Circuit recognized that, in reviewing petitioners' claim *de novo*, it was "more likely to disagree with the fiduciary's claims determination . . ." 907 F.2d at 558; A-21. The Fifth Circuit did not accept the petitioners' "strained interpretation . . .", and simply "declined to interpret such provisions contrary to their plain meaning . . ." 907 F.2d at 561; A-26.

Petitioners assert the Court should have applied other common law rules of contract interpretation, including the doctrine of

contra proferentem. Thus, reason petitioners, their interpretation prevails and the Fifth Circuit erred in applying the "plain meaning" of the Plan's terms.[5] Rules of interpretation serve as aids in ascertaining the intent of the parties as embodied in the written document. 17A C.J.S. *Contracts* § 294 p.23 (1963); Restatement (Second) of Contracts § 202, p.86 (1981). The principles independently establish no rule of law ascribing meaning. Indeed, the principle of interpretation that a contract is to be construed against its maker is the last principle of interpretation, to be utilized only when other canons have failed to show the intent of an ambiguous provision. *See, e.g., DeGeare v. Alpha Portland Ind., Inc.*, 837 F.2d 812, 816 (8th Cir. 1987), *rev'd on other grounds*, 109 S. Ct. 1305 (1989); *Lippo v. Mobil Oil Corp.*, 776 F.2d 706, 714 n.15 (7th Cir. 1985); *Schering Corp. v. Home* Ins. Co., 712 F.2d 4, 10 n.2 (2d Cir. 1983); *Combined Comm. Corp. v. Seaboard Surety Co.*, 641 F.2d 743, 745 (9th Cir. 1980); *Quad Constr. Inc. v. Wm A. Smith Contracting Co.*, 534 F.2d 1391, 1394 (10th Cir. 1976); 17A C.J.S. *Contracts* § 324 pp. 224-25 (1963). Simply put, there is no reason to grant review.

B. The Dow Program's interpretation of the Plan was properly affirmed by the District Court and Court of Appeals.

The lower courts' interpretation of the Plan was correct.[6] The Dow Program agrees that the distinction between the two provi-

[5] Petitioners appear to acknowledge that looking to a contract's terms and giving them their plain meaning is an accepted canon of construction and the "starting point" for interpretation. (Petition, pp. 14, 17). Many of their further arguments (*e.g.*, Petition pp. 18-21) simply presuppose a version of the facts which the lower courts rejected. The providing of benefits initially was based upon petitioners' representations, *not* an interpretation of the Plan.

[6] Petitioners also assert that this Court should grant review, because the Fifth Circuit stated that the available benefits under the Plan were limited to the Home Health Care section, rather than the Personal

(footnote continued on next page)

sions of the plan, "Personal Physician" and "Home Health Care", was not focused upon by the parties or the district court below. There, the sole issue was whether the care provided to Mrs. Cathey was primarily custodial. *All* agreed that the Plan did provide coverage for medically necessary services and did not provide coverage for custodial services (Tr. 5, 6, 8). The Dow Program defended below on the grounds that the registered nursing services were not medically necessary and that the services being provided were custodial. Petitioners argued the care was medically necessary and was not custodial.

Having lost the battle in the district court that the services being provided were primarily custodial and did not require a registered nurse to perform them, the Catheys changed emphasis and argued to the Fifth Circuit[7] and to this Court (Petition pp. 20-23) that custodial services were not excluded because the in-home registered nursing services were actually covered under the "Personal Physician" provisions, which they asserted did not exclude custodial services.

1. *The Plan Does Not Provide For Unlimited In-home Nursing Care.* The Catheys now claim that, since the Old Plan paid for nursing services under the Supplemental Benefits coverage, the

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Physician section. (Petition at 18). That argument ignores the fact that the District Court found, under either a *de novo* or an abuse of discretion standard, that the claims were properly denied under the Personal Physician Section of the Plan, because the around-the-clock skilled nursing care would be predominantly custodial in nature and did not require a skilled nurse. (A-32). The Fifth Circuit did not question, or find clearly erroneous, that factual finding with respect to the Personal Physician portion of the Plan. 907 F.2d at 560; (A-24). Therefore, the decision to deny the claims for around-the-clock skilled nursing care under the Personal Physician Section of the New Plan is supported both by the Fifth Circuit's interpretation of the Plan and the District Court's factual finding after *de novo* review. Petitioners' asserted "conflict" between the reasoning of the District Court and the Fifth Circuit would not change the decision on the merits one iota.

[7] Brief of Appellant (pp. 13-15).

New Plan must now provide unlimited in-home registered nursing services under the Personal Physician coverage.[8] What petitioners gloss over in their argument to this Court is the undisputed facts. Dr. Torp, Mrs. Cathey's physician, testified that an LVN (licensed vocational nurse) could provide the services (Tr. 75-78),[9] as could one with no formal medical training (Tr. 75-78). Where services can be performed by one not a registered nurse, the use of a registered nurse to provide those services is simply not medically necessary. Since a registered nurse is not required, the Personal Physician provision upon which they rely is not applicable. The District Court's well girded factual findings, upheld by the Fifth Circuit, demonstrate this fact (A-32, Nos. 14-15; R. 72, Nos. 14-15).

Aside from ignoring the evidentiary basis demonstrating the inapplicability of this provision to their position, petitioners argue strained interpretations of correspondence sent after the denial to support their position. The March 8 denial letter unequivocally states that in-home nursing care is limited to 50 visits per year. It states that in-home care is

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[8] The Petitioners' continued claim that the Old Plan and the New Plan should be read as one document was correctly rejected by the Fifth Circuit. The S.P.D. (Summary Plan Description) carefully and clearly distinguishes the provisions of the two plans (DX-31 overlay, and pp. 1, 2, and 10). The fact that some of the provisions of the New Plan and the Old Plan are similar cannot ignore the fact that the New Plan includes a limitation on the amount of home health care. The New Plan defines and excludes custodial care. The New Plan, unlike the Old Plan, provides for home health care, otherwise excluded from coverage. Further, the New Plan, as did the Old Plan, expressly excludes care which is not "medically necessary" under prevailing medical standards.

[9] Dr. Torp, in a letter dated November 5, 1984, said that the in-home services could be performed by one not a registered nurse (DX-17). The fact that the Personal Physician provision only covers services provided by a *registered* nurse (A-60; DX-31, p. 14) perhaps explains why the Petitioners did not argue at trial what they now urge.

> covered under the New Plan and 100% of the reasonable and customary costs up to a maximum of 50 visits in a calendar year for up to four (4) hours per visit, if provided through an approved home health care agency. The physical therapy services Mr. McArdle describes would be covered at 80% of the reasonable and customary charges.

(A-68; DX-28). *The basis for payment of the nurse's services was the therapy services performed* by the nurse, *not* any medically necessary care requiring a registered nurse.[10] The therapy services were authorized under the Personal Physician coverage (at 80% coverage subject to the 365 day limitation).

The simple fact is that the evidence below clearly showed the care being provided was custodial and all services being performed did not require a registered nurse. Coverage under the Personal Physician provision of the Dow Program was properly denied. However, coverage of medically necessary care is covered under the Home Health Care and therapy provisions of the Plan. This is what the Dow Program's administrators held (A-68; DX-28).

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[10] It was the therapy services that the claims consultant found covered (A-64-65; DX-20); it was these services which were found medically necessary and covered by the Plan (A-64-65; DX-20; A-69-70; DX-27) and which formed the basis for the Plan's payment at 80% to the nurse (A-68; DX-28, 26).

Petitioners additionally rely on a May 7, 1985 letter from the Plan's attorney (Petition pp. 21-22). This letter is consistent with the other actions and communications of the Dow Program. It is not now, nor has it ever been the position of the Dow Program that all nursing services are covered under the Home Health Care provision. Indeed, registered nursing services are clearly listed under the Personal Physician provision (A-74; PX-30, p. 1). As the letter pointed out, the New Plan does provide coverage for 80% of in-patient or out-patient medically necessary, skilled nursing care. Nursing care provided in the home under the Home Health Care provision is covered at 100%. The Dow Program's interpretation of its provisions has been consistent and in accordance with the reasonable interpretation of the Personal Physician and Home Health Care provisions.

II. ERISA PREEMPTION IS NOT PROPERLY AT ISSUE AND IS WELL SETTLED BY PRIOR DECISIONS OF THIS COURT.

In the last several pages of their petition, petitioners attempt to justify their request for *certiorari* by portraying this as an opportunity to decide principles of ERISA preemption (Petition at 24-28). Petitioners make oblique references to ERISA's "saving" and "deemer" clauses, and suggest that this is a reason to review this case. Petitioners apparently anticipate a ruling from the Texas Supreme Court - in a different lawsuit involving the same coverage issue under the Dow Program but naming other defendants - that ERISA will preempt the petitioners' state law theories of recovery. Petitioners concede, as they must, that the ERISA preemption issue is "not ripe for decision, because the Texas Supreme Court has not yet ruled . . ." (Petition at 28).

Even if the Texas Supreme Court had already ruled in favor of respondent on the ERISA preemption question, this holding would be both consistent with and mandated by the prior decisions of this Court. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); and, *Ingersoll-Rand Co. v. McClendon*, 111 S. Ct. 478, ___ U.S. ___ (1990). Since this Court has ruled that ERISA's exclusive civil enforcement mechanism preempts all state law remedies, a ruling by the Texas courts in favor of ERISA preemption of petitioners' state law theories of recovery will not provide a basis for a writ of *certiorari*.

CONCLUSION

The questions that petitioners raise are neither special nor important. The contractual interpretation and factual findings made by the Fifth Circuit and the District Court involve no unsettled questions of law and are entirely consistent with the prior rulings of this Court on ERISA claims matters. Respondent respectfully submits that this petition should be denied.

Respectfully submitted,

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PETITIONERS' REPLY BRIEF

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PETITIONERS' REPLY BRIEF

I.

CITATION OF SUPPLEMENTAL AUTHORITY

The primary point Petitioners have made is that consideration of this petition is justified because in the related state court suit the Texas courts held that all remedies under state law are preempted, including relief sought under provisions of the Texas Insurance Code explicitly regulating the practices of insurers in selling policies and handling claims. The Texas Supreme Court on January 30, 1991, unanimously affirmed the decisions of the lower courts. The issue of preemption is now ripe for consideration.

The majority opinion in *Cathey v. Metropolitan Life Insurance Co.*, __S.W.2d__, 34 Tex. Sup. Ct. J. 309 (Jan. 30, 1991), relied on this Court's decision in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), to hold that

even if Article 21.21 of the Texas Insurance Code could be considered within the "saving" clause of ERISA, the statute would still be preempted because of the Texas court's view that under *Pilot Life* ERISA provides the exclusive remedy, notwithstanding the language of the saving clause. (Slip op. at 7-8). This is precisely the sort of analysis anticipated in the Catheys' petition for writ of certiorari. (*See* Petition 27-28). The concurring opinion in *Cathey v. Metropolitan* noted the "deplorable" result of eliminating state remedies under laws expressly regulating insurance, but even the concurring justices felt no alternative existed in light of their construction of decisions from this Court.

As pointed out by the concurring opinion in *Cathey v. Metropolitan*, ERISA affects over fifty-six million Americans who are enrolled in group health insurance plans. As the Dow Program's response points out, this Court has found ERISA sufficiently important to grant review on a number of occasions to expound on the expansiveness of ERISA preemption. *See Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987); *Ingersoll-Rand Co. v. McClendon*, 111 S. Ct. 478 (1990). The same pervasive importance of ERISA reflected by the grant of review in these cases warrants review in the present case.

The procedural posture of this case, now that the Texas Supreme Court has ruled, presents a unique opportunity for this Court to fill in vital missing parts of the ERISA equation. This Court has written extensively on preemption. Now is the time for the Court to define the limits, if any, of that preemption.

The question presented by the Texas Supreme Court's decision is whether ERISA can preempt a state law regulating unfair insurance practices that was enacted pur-

suant to the McCarran-Ferguson Act, even though the "saving" clause of ERISA explicitly saves from preemption "any law of any State which regulates insurance." Specifically, can such a statute be preempted as conflicting with ERISA's enforcement scheme, when Congress explicitly stated that such state laws were not to be preempted?

As framed by the Texas Supreme Court in *Cathey v. Metropolitan*, and cases cited in that opinion, the issue turns on the proper reading of *Pilot Life*. When this Court went on to hold that additional, inconsistent remedies were preempted, after the Court already held the common law remedy at issue was not "saved" as a law regulating insurance, was the second holding perhaps overly-broad dicta that has been improperly expanded beyond the context of *Pilot Life*? Or, did this Court mean to hold in *Pilot Life* that even a state law that fits within ERISA's express saving clause is nevertheless preempted? If the former construction is correct, then *Cathey v. Metropolitan* and a score of other cases are wrong and need to be reversed and disapproved. If the latter reading prevails, this Court needs to explain how the saving clause can be effectively read out of ERISA in deference to the preemption clause, especially in light of *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), and the more recent decision in *FMC Corp. v. Holliday*, 111 S. Ct. 403 (1990).

The Catheys' concession, and the Dow Plan's argument, that the preemption issue was not yet ripe for review are no longer correct. As shown by the appended opinions and judgment of the Texas Supreme Court, the time to decide the preemption question is now. The preemption issue is a question of far-reaching importance, which the Catheys will present more fully in their petition for certiorari in *Cathey v. Metropolitan*.[1]

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[1] This petition is due to be filed by April 30, 1991.

The second important issue, which is directly presented by the pending petition, is the question of what remedies and rights beneficiaries are to have under ERISA if all state remedies are in fact preempted.

This Court's ERISA jurisprudence to this point has been for the most part limited to decisions that forbid as preempted various state law remedies and regulations. The Court has also held that lower courts are to develop a federal common law of rights and remedies to protect participants and beneficiaries under ERISA plans. The Court has not had an opportunity, until now, to give meaning to that mandate. This case squarely presents the opportunity for the Court to give life to the promise of meaningful rights and remedies under the federal common law of ERISA.

As previously briefed, the problem with the opinion of the court of appeals in this case is that the court entirely failed to adopt, acknowledge, or apply any legal principles in reaching or explaining its decision denying the Catheys recovery under ERISA.

The two questions presented in this case and in *Cathey v. Metropolitan* are inextricably related. If the Court determines that all state laws are preempted, even those aimed at regulating insurance sales and claims handling, then definitive guidance on the scope and development of remedies and rights under the common law of ERISA is urgently needed. Otherwise, this Court's preemption holdings merely create a vacuum in which insurers can act with almost complete impunity, because all state laws are preempted, and federal law is impotent. On the other hand, if the Court applies the saving clause to reject preemption of state laws regulating insurance, the continued vitality of state law protections allows for more orderly development of federal common law, and such state law remedies provide the analytical base for developing

meaningful federal common law remedies.

The Catheys respectfully pray that this Court grant review in this case, or stay consideration of this petition, consolidate the two cases for review, and then grant review of both petitions.

II.

REPLY TO RESPONDENT'S BRIEF

One misstatement that appears throughout the Dow Program's response is the contention that the district court's fact findings were not disturbed on appeal. (*See* Response 2 n. 1, 8-9 n. 6, 10). The relevance of this assertion is not clear, but the assertion is clearly wrong, whatever the relevance.

The Dow Program asserts three bases for the claim denial: (1) the nurse's services were not medically necessary; (2) the services were primarily custodial; and (3) the services could be performed by a person without professional training. (Response 4). These bases were accepted and affirmed by the district court (App. 32-33). However, the Fifth Circuit rejected each of these grounds. The Fifth Circuit characterized as "draconian" the Dow Program's position that the performance of gratuitous custodial services along with skilled nursing services allowed the administrator to deny all compensation, 907 F.2d at 557 (App. 17), and the court rejected that position as being not supported by the language of the plan. *Id.* at 561 (App. 27-28). The Fifth Circuit also dismissed the Dow Program's "self-serving" assertions that certain training and professional skills were required of the nurse. *Id.* at 557 & n.4 (App. 18).

The point of this appeal is that the Fifth Circuit disagreed with the grounds for denial asserted by the Dow Program and disagreed with the essential conclusions

drawn by the district court, but still denied the Catheys any relief. The Fifth Circuit grounded its decision on its interpretation of the plan documents as governing in-home nursing services *exclusively* under the "Home Health Care" language of the New Plan, without regard to the alternate language covering services of a registered nurse that were prescribed by a physician. The Fifth Circuit, *sua sponte,* read the "Personal Physician" language as covering only "non-home" medical services. 907 F.2d at 561 (App. 26-27).

The Dow Program admits this was not the issue upon which the parties tried the case (Response 8-9), and the Fifth Circuit's interpretation was not one ever advanced by the Dow Program or the district court. In fact, the Dow Program disavows the Fifth Circuit's holding, by stating:

> It is not now, nor has it ever been the Dow Program's position that all nursing services are covered under the home Health Care provision. Indeed, registered nursing services are clearly listed under the Personal Physician provision[.]
> . . .

(Response 11 n. 10).

The Dow Program also provides a complete rebuttal to the Fifth Circuit's view that the Home Health Care language was the exclusive provision governing *in-home* medical services. The Dow program admits that it paid for *in-home* therapy services performed by Nurse Jurek at 80% under the services prescribed by a "Personal Physician" language of the New Plan. (Response 10-11 & n. 10). Yet *in-home* therapy services are covered at 100% by the Home Health Care provision as well (App. 59), just as nursing services are covered by *both* the Home Health Care and Personal Physician provisions of the New Plan. (App. 59-61). The Dow Program's own admitted practice of paying for

in-home therapy services under the Personal Physician provision renders absurd the Fifth Circuit's holding that the Home Health Care provision exclusively governed in-home medical services.

By ignoring the interpretation given to the contract by the Dow Program, the Fifth Circuit violated one of the basic tenets of contract construction, the rule providing tha the meaning given by the parties will control. As previously briefed, the Fifth Circuit's construction, by failing to articluate or adopt any principles of federal common law, also ignored the rule that the plain meaning of the contract should control, the rule that the interpretation given by the contract's drafter is entitled to great weight, and the rule requiring that related contracts are to be construed together, especially as in this case when the provisions of the Old Plan and New Plan appeared in the same document.

The Dow Program halfheartedly asserts that the Fifth Circuit did apply the "plain meaning" rule, but the Dow Program does not and cannot assert that the Fifth Circuit's application of that rule was correct. Significantly, nowhere in its brief does the Dow Program argue that the Fifth Circuit's interpretation of the documents was right. Instead, as set forth above, the Dow Program disavows and rebuts the interpretation given by the Fifth Circuit.

The reason the Dow Program cannot embrace the Fifth Circuit's holding, and the reason this Court should not allow the Fifth Circuit's decision to stand is that quite simply the words appearing in the same plan document cannot have different meanings on different days. The Dow Program paid for Nurse Jurek's in-home nursing services for over two years under the language of the Old Plan promising coverage for registered nursing services prescribed by a physician. There is simply no principle under which those same services could not be covered under the same

language in the New Plan.[2]

Simply mouthing and misapplying the "plain meaning" rule of contract construction is hardly what this Court could have intended when it instructed lower courts to develop a body of federal common law principles to govern rights and remedies under ERISA.

The Fifth Circuit expressly rejected the grounds given by the Dow Program and the district court for denial of the Catheys' claim. The Dow Program disavows the basis the Fifth Circuit has given for upholding the denial. Yet the Catheys still lose.

Unable to embrace the erroneous construction given by the Fifth Circuit, the Dow Program instead tries to argue that this is really such a small case as to be unworthy of review. The Catheys vehemently disagree. No one disputes the debilitating physical harm being endured by Bette Cathey, but the decision of the Fifth Circuit does not harm only the Catheys. This case is of broad public importance, as well. The need for meaningful, fair principles of federal common law to govern ERISA claim determinations affects every claim and every claimant under ERISA.

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[2] There is one principle that could explain the result, but it is hardly one the Dow Program is likely to embrace or that this Court would endorse.

> "When I use a word," Humpty Dumpty said in a rather scornful tone, "it means just what I choose it to mean — neither more nor less."
>
> "The question is," said Alice, "whether you *can* make words mean so many different things."
>
> "The question is," said Humpty Dumpty, "which is to be master — that's all."

L. Carroll, *Through the Looking-Glass and What Alice Found There*, ch. 6 (1865).

The Catheys do not just disagree with the result reached by the Fifth Circuit; the entire process by which that decision was reached is indicted. The Catheys have shown that if the Fifth Circuit had applied any meaningful, fair principles of federal common law, based upon universally accepted principles of contract law, the result could not have been reached.

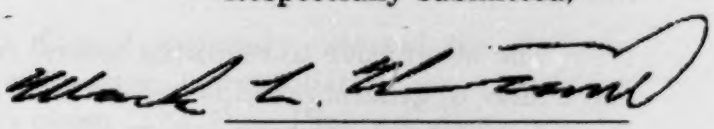
The alternative to requiring federal courts to adopt and adhere to general principles of contract interpretation, applied as federal common law in ERISA cases, is that there will be no compass by which to decide these cases. ERISA purports to give a remedy for benefit denials, but the lack of any standards to govern judicial review makes any such remedy arbitrary and wholly discretionary. This can hardly be what Congress intended when it enacted ERISA to "promote the interest of employees and their beneficiaries in employee benefit plans" and "to protect contractually defined benefits."

It is somewhat hollow to argue, as the Dow Program does, that this ERISA case is merely a private dispute of little public importance, when one considers the raft of ERISA decisions issued by this Honorable Court. The fifty-six million Americans whose health safety net is ERISA are entitled, at bare minimum, to a federal common law embracing universally accepted rules of contract construction.

The Catheys respectfully pray that this Honorable Court grant their petition in this case to clarify the duty of federal courts to adopt and apply federal common law principles to govern rights and liabilities under ERISA. The Catheys further pray that consideration of this petition be consolidated with their forthcoming petition in *Cathey v. Metropolitan*, presenting the issue of preemption of state insurance laws. Ultimately, the Catheys pray that this Court hold that the Catheys' state insurance law remedies

are saved from preemption and that under properly applied principles of federal common law, the Catheys are entitled under ERISA to the benefits they claim.

Respectfully submitted,



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SUPPLEMENTAL APPENDIX A

IN THE SUPREME COURT OF TEXAS

NO. C-8323

JAMES C. CATHEY and BETTE CATHEY	§	
Petitioners	§	FROM HARRIS COUNTY
v.	§	
	§	FIRST DISTRICT
METROPOLITAN LIFE INSURANCE CO., DOW CHEMICAL CO. and MICHAEL H. MADDOLIN	§	
Respondents	§	

OPINION

This is an appeal in a case involving "ERISA," the Employees' Retirement Income Security Act of 1974. 29 U.S.C. §§ 1001-1461 (1988). An employee and his wife brought state law claims against his employer and its insured for alleged wrongful denial of a claim for in-home nursing care. The trial court granted a summary judgment to the defendants. The court of appeals affirmed the judgment of the trial court. 764 S.W.2d 286. We are called upon to decide whether causes of action stated under: 1) article 21.21, section 16 of the Texas Insurance Code; 2) section 17.50(a)(4) of the Texas Deceptive Trade Practices Act; and 3) article 3.62 of the Texas Insurance Code are superseded by the provisions of ERISA. We hold that ERISA preempts these causes of action in this case. We therefore affirm the judgment of the court of appeals.

FACTS

Because this is a summary judgment case, the facts shown by the Catheys are taken as true. *Nixon v. Mr. Property Management Co.*, 690 S.W.2d 546, 548-49 (Tex. 1985). James Cathey was employed as a purchasing agent for Dow Chemical Company ("Dow") from 1973 to 1983. During his tenure at Dow, Cathey was told by Dow representatives that he and his wife, Bette Cathey, were covered by a group insurance plan (the Dow plan). In the mid-1970's Bette Cathey was diagnosed with multiple sclerosis, and her condition worsened so that eventually she could no longer walk without assistance. In 1982, Bette Cathey's physicians ordered home nursing care for her. These expenses were paid for under the group insurance plan covering Dow employees. In 1985, Metropolitan Life Insurance Company ("Met"), acting as the claims administrator for the Dow plan, refused to continue paying for the nursing care. Cathey contacted Michael Maddolin, group claim consultant with Met, who told him that there was no medical necessity for nursing care for Bette Cathey.

The Catheys filed suit against Dow, Met, and Michael Maddolin alleging common law and statutory causes of action; no ERISA causes of action were stated. The trial court found each cause of action to be preempted by ERISA and, following the Catheys' refusal to amend their petition to state an ERISA cause of action,[1] rendered summary judgment in favor of Dow, Met, and Maddolin. The court of appeals affirmed that judgment.

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[1] The Catheys filed a separate ERISA suit against the Dow Chemical Company Medical Care Program during the pendency of this action. We note that the Fifth Circuit handed down its decision in that case on August 3, 1990, holding that the Catheys were entitled to partial recovery on their ERISA claim. *Cathey v. Dow Chemical Co. Medical Care Program*, 907 F.2d 554 (5th Cir. 1990).

ERISA

The Employee Retirement Income Security Act of 1974 subjects employee benefit plans to federal regulation. The act regulates both pension plans and welfare plans that provide benefits for contingencies such as illness, accident, disability, death, or unemployment. While it provides standards and rules governing reporting, disclosure, and fiduciary responsibility for pension and welfare plans, ERISA does not mandate any particular benefits. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90-91 (1983).

Section 1144(a) of ERISA provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title.

This section is informally known as the "preemption" provision of ERISA. It is narrowed in scope by subsection 1144(b)(2)(A), commonly known as the "saving" clause:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities.

Subparagraph 1144(b)(2)(B), the "deemer" clause, modifies the saving clause by providing that no employee benefit plan:

> shall be deemed to be an insurance company or other insurer . . . for purposes of any law of any state purporting to regulate insurance companies.

The operation of these provisions has been succinctly explained by the United States supreme Court:

> To summarize the pure mechanics of the provisions quoted above:
> If a state law "relate[s] to . . . employee benefit plan[s]," it is pre-empted. The saving clause excepts from the pre-emption clause laws that "regulat[e] insurance." The deemer clause makes clear that a state law that "purport[s] to regulate insurance" cannot deem an employee benefit plan to be an insurance company. (citations omitted).

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 45 (1987).

Section 1001(b) of Title 29 declares that it is the policy of ERISA to protect:

> the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

29 U.S.C. § 1001(b) (1988). In *Pilot Life*, the Supreme Court explained that the preemption provision of ERISA was intended to have the effect of "reserv[ing] to Federal authority the sole power to regulate the field of employee benefit plans." 481 U.S. at 46 (quoting Representative Dent, 120 Cong. Rec. 29197 (1974)).

THE DISPUTE

The Catheys contend that misrepresentations made

by representatives of both Dow and Met are actionable under the Texas Insurance Code and Deceptive Trade Practices Act ("DTPA"). They argue that their claims do not "relate to" an employee benefit plan and thus are not preempted. In the alternative, the Catheys assert that even if their claims do relate to an employee benefit plan within the meaning of the preemption provision, they are preserved by the saving clause as laws regulating insurance.

Dow, Met, and Maddolin assert that section 16 of article 21.21 and article 3.62 of the Texas Insurance Code, and section 17.50(a)(4) of the DTPA are state laws that "relate to" an ERISA plan and are therefore preempted. They further contend that the causes of action alleged by the Catheys are not saved from preemption by the saving clause because they conflict with the civil enforcement scheme provided in ERISA and are therefore displaced. Both Dow and Met pleaded ERISA preemption in their answers; Maddolin did not.

"RELATE TO"

A state law, defined in section 1144(c)(1) to include all laws, decisions, rules, regulations, or other action having the effect of law, is preempted by ERISA only if it "relates to" a plan. 29 U.S.C. § 1144(a) (1988). We must therefore begin with the fundamental inquiry: When does a state law relate to an employee benefit plan?

The United States Supreme Court has loosely defined the parameters of the "relate to" requirement. "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection or reference to such a plan." *Shaw*, 463 U.S. at 96-97. Also the Court declared that "[t]he phrase 'relate to' was given its broad commonsense meaning." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). The Court has

repeatedly stated that the words "relate to" should be construed expansively. *See Shaw,* 463 U.S. at 96-97; *Pilot Life,* 481 U.S. at 46-48; *Fort Halifax Packing Co. v. Coyne,* 482 U.S. 1, 8 (1987). ERISA preemption applies not only to state laws but to all forms of state action dealing with the subject matters covered by this federal statute. 29 U.S.C. § 1144(c)(1) (1988); *see also Shaw,* 463 U.S. at 98. In keeping with this broad interpretation, the Court held that a cause of action for wrongful termination related to an ERISA plan where it was based on the allegation that the employer fired the employee to avoid paying benefits under a pension plan. *Ingersoll-Rand Co. v. McClendon,* 111 S. Ct. 478 (1990).[2]

Given these declarations by the Supreme Court, courts have not hesitated to find that state laws having an effect on employee benefit plans relate to such plans and are therefore preempted by ERISA. *See, e.g., Ramirez v. Inter-Continental Hotels,* 890 F.2d 760 (5th Cir. 1989); *Boren v. N.L. Indus.,* 889 F.2d 1463 (5th Cir. 1989), *cert. denied.*, 110 S. Ct. 3283, 111 L. Ed. 2d 792 (1990); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters.,* 793 F.2d 1456 (5th Cir. 1986), *cert. denied,* 479 U.S. 1034 (1987); *Kanne v. Connecticut Gen. Life Ins. Co.,* 867 F.2d 489, *cert. denied* 109 S. Ct. 3216, 106 L. Ed. 2d 566 (1989); *Misic v. Building Serv. Employees Health & Welfare Trust,* 789 F.2d 1374 (9th Cir. 1986); *Juckett v. Beecham Home Improvement Prods., Inc.,* 684 F. Supp. 448 (N.D. Tex. 1988); *E-Systems, Inc. v. Taylor,* 744 S.W.2d 956 (Tex. App.—Dallas 1988, writ denied); *Giles v. Texas Instruments Employees Pension Plan,* 715 S.W.2d

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[2] Also, we note that the Supreme Court handed down *FMC Corporation v. Holliday* contemporaneously with *McClendon,* 111 S. Ct. 403 (1990). However, that opinion does not impact our decision in this case. In *Holliday,* the Court considered whether a state law prohibiting subrogation claims fell within ERISA's insurance saving clause. The state law did not conflict with ERISA's exclusive remedy scheme.

58 (Tex. App.—Dallas 1986, writ ref'd n.r.e.); *Felts v. Graphic Arts Employee Benefits Trust,* 680 S.W.2d 891 (Tex. App.—Houston [1st Dist.] 1984, no writ). "Because of the breadth of the preemption clause and the broad remedial purpose of ERISA, 'state laws found to be beyond the scope of [the preemption provision] are few.' " *Cefalu v. B.F. Goodrich Co.,* 871 F.2d 1290, 1294 (5th Cir. 1989).

The common law claim in *Pilot Life* was not alleged against the employee benefit plan, but against the insurance company that administered the plan. Nevertheless, the Court noted that the cause of action clearly related to a plan and was thus preempted. 481 U.S. at 47-48; *see also Ramirez,* 890 F.2d at 760, 762-63 (suit brought against former employer and its insurance carrier held to be preempted); *Cefalu,* 871 F.2d at 1292-93 (suit related to an ERISA plan even though it was alleged against the former employer and not the plan). The Catheys' claim for nursing care was made and denied pursuant to the Dow plan's terms, and they appealed this denial under the internal review provisions of the plan. We hold that the Catheys' claims against Dow and Met relate to an employee benefit plan; the claims are thus preempted unless a contrary result is mandated by the saving clause.

ERISA'S EXCLUSIVE REMEDY SCHEME v. THE SAVING CLAUSE

The Catheys assert that even if their claims relate to an employee benefit plan, they are saved from preemption by section 1144(b)(2)(A), the saving clause. The saving clause saves from preemption state laws which regulate insurance. *Metropolitan Life,* 471 U.S. at 737; *Pilot Life,* 481 U.S. at 47. However, even the saving clause cannot save from preemption a state law that provides remedies not provided by ERISA. In *Pilot Life,* the Supreme Court announced that ERISA's civil enforcement remedies were

intended to be exclusive. 481 U.S. at 54. *Pilot Life* involved allegations of improper processing of a claim for benefits. In holding that the plaintiff's claim for breach of the Mississippi common-law duty of good faith and fair dealing was preempted by ERISA, the court stated, "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Id.; see also McClendon,* 111 S.Ct. at 484-85; *Mutual Life Ins. Co. v. Yampol,* 840 F.2d 421, 425 (7th Cir. 1988).

Even if these insurance code provisions and the DTPA provisions were subject to the saving clause, the Court's opinions in *Pilot Life* and *McClendon* held that Congress intended all suits alleging improper claims processing be governed only by ERISA. *McClendon,* 111 S.Ct. at 485; *Pilot Life,* 481 U.S. 52-54. Section 16 of article 21.21 and article 3.62 of the Insurance Code and section 17.50(a)(4) of the DTPA provide recovery that was not included under ERISA. The Court has decided that ERISA's civil enforcement scheme could not be supplemented by state law remedies. Therefore, a statutory remedy for improper claims processing is not available against an ERISA plan or its administrator.

CONCLUSION

The Catheys seek to recover remedies not available under ERISA's civil enforcement provisions. Therefore, even if the provisions in question could be said to regulate the business of insurance for purposes of ERISA preemption analysis, they would still be preempted as laws that provide remedies that are inconsistent with the civil enforcement provisions provided in ERISA. *See Pilot Life,* 481 U.S. 51-57; *Massachusetts Mutual Life Ins. Co. v.*

Russell, 473 U.S. 134, 146 (1985); *Ramirez*, 890 F.2d at 764; *Kelley v. Sears, Roebuck & Co.*, 882 F.2d 453, 456 n.2 (10th Cir. 1989); *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 493-94 (9th Cir. 1988), *cert. denied*, 109 S. Ct. 3216, 106 L. Ed. 2d 566 (1989); *In re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194 (8th Cir. 1988); *Anschultz v. Connecticut Gen. Life Ins. Co.*, 850 F.2d 1467, 1469 (11th Cir. 1988); *Juckett v. Beecham Home Improvement Prods.*, 684 F. Supp. 448 (N.D. Tex. 1988); *McManus v. Travelers Health Network*, 742 F. Supp. 377 (W.D. Tex. 1990); *Commercial Life Ins. Co. v. Superior Court*, 764 P.2d 1059 (Cal. 1988), *cert. denied sub nom, Juliano v. Commercial Life Ins. Co.*, 109 S. Ct. 2087, 104 L. Ed. 2d 651 (1989). Accordingly, we hold that Texas Insurance Code section 16 of article 21.21 and article 3.62 as well as DTPA section 17.50(a)(4) are preempted by the provisions of ERISA in the context of the facts of this case. Dow and Met properly pleaded ERISA preemption in their answers; Maddolin did not. We agree with the court of appeals, however, that the preemption of the Catheys' claims against Dow and Met extends to Maddolin because he acted as Met's employee in the course of its business. We therefore affirm the judgment of the court of appeals.

RAUL A. GONZALEZ
Justice

OPINION DELIVERED: January 30, 1991

Concurring opinion by Justice Doggett joined by Justices Mauzy, and Gammage.

SUPPLEMENTAL APPENDIX B

IN THE SUPREME COURT OF TEXAS

NO. C-8323

JAMES C. CATHEY AND BETTE CATHEY, Petitioners,	§	
	§	FROM HARRIS
v.	§	COUNTY
	§	
	§	FIRST DISTRICT
METROPOLITAN LIFE INSURANCE CO., DOW CHEMICAL CO. and MICHAEL H. MADDOLIN, Respondents.	§	

CONCURRING OPINION

In one brief writing the court today is forced to eliminate the rights of hundreds of thousands of Texas families to protect themselves from false, misleading, and deceptive practices in the handling of health and disability insurance claims. These are rights that had been secured by consumer protection statutes properly enacted by the Texas Legislature and that remain in effect today for those Texans who obtain their coverage directly from insurers rather than through their employers. Unfortunately, there is little that I or any other member of this court can do about this deplorable demise of state-given rights other than to lament their passage.

Recognizing that *Ingersoll-Rand v. McClendon,*

— U.S. —, 111 S. Ct. 478 (1990), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), control this case, I must concur with the court's opinion. By its reading of ERISA's preemption clause, the United States Supreme Court has restricted the very rights of employees—to avoid the delay or denial of benefits—that Congress sought to protect. Through peculiar federal judicial interpretation, a statutory addition to workers' rights has been converted into a statutory removal of those rights. The law has been reshaped into a form that achieves the converse of its original purpose. Identical claims are now treated differently depending on whether the claimant is insured individually or through an employer. Those insured through their employers are denied by ERISA preemption the safeguards afforded by Texas to their fellow citizens. I join with the growing number of courts and commentators who express the concern that through continued misconstruction, ERISA has become "quicksand" that "will continue to expand and to preempt everything in its meandering path." *Jordan v. Reliable Ins. Co.*, 694 F. Supp. 822, 835 (N.D. Ala. 1988). For the over 56 million Americans who are enrolled in group health insurance plans like the one in which James Cathey was a member,[1] ERISA has become more than mere quicksand; it has become a black hole.

Through ERISA, Congress sought "to assure that individuals who have spent their careers in useful and socially productive work will have adequate incomes to meet their needs when they retire." H. Rep. No. 807, 93d Cong., 2d Sess. 3, *reprinted in* 1974 U.S. Code Cong. & Admin. News 4639, 4670. The measure responded to increasing abuses against workers caused by irresponsible management of pension and welfare benefit funds. In its "declaration of policy," Congress noted:

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[1] U. S. Census Bureau, 1990 Statistical Abstract 413 (1990).

> that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits.

29 U.S.C. § 1001(a) (1974). The primary objective of the legislation was "to increase the rights of employees by imposing strict fiduciary duties on employers and benefit plan administrators and by providing the employees with the civil remedies in section 502(a)." Note, *Punitive Damages and ERISA: An Anomalous Effect of ERISA's Preemption of Common Law Actions,* 65 Wash. U.L.Q. 589, 609 (1987).

In view of this laudable goal, several commentators have expressed dismay at the paradox that has arisen since *Pilot Life:* the workers ERISA was intended to protect lack a remedy for wrongs unaddressed by the statute, while the companies targeted by Congress employ ERISA as an effective shield against responsibility for wrongful processing of claims. The first manifestation of this incongruous result is that workers covered by group benefit plans have been denied state causes of action that had been available prior to the Act's passage. *Id. See also,* Note, *Blind Faith Conquers Bad Faith: Only Congress Can Save Us After Pilot Life Insurance Co. v. Dedeaux,* 21 Loy. L.A.L. Rev. 1343, 1381 n.303 (1988) (hereinafter Note, *Blind Faith*) (observing the lack of Congressional intent to preempt state causes of action for breach of a covenant of good faith and fair dealing). Second, persons covered by group benefit

plans are limited to ERISA's remedies, while individual insurance policyholders retain the full range of state remedies. *Id.* at 1347.[2] The harm is exacerbated by the reality that employees seldom have a voice in selecting their company's group insurer. Whether taken separately or together, these developments evince a disturbing disregard for Congress' overriding intent to protect the participants and beneficiaries of group benefit and pension plans. Their aim is best served by reading ERISA's remedies as a floor rather than a ceiling, and by respecting the traditional deference given to state insurance regulations as mandated by the McCarran-Ferguson Act, 15 U.S.C. § 1011. Under ERISA, insurers who provide group benefit plans have little incentive to deal promptly and fairly with employee participants.[3] Indeed, for ERISA to

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[2]The Supreme Court reinforced a third curious distinction—that between self-insured plans and those that obtain insurance from regulated insurance companies—in *FMC Corp. V. Holliday*, — U.S. —, 111 S.Ct. 403 (1990), discussed in the majority opinion, *supra*, — S.W.2d at — n.1. This distinction was introduced by the Court in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985). In his dissent to *Holliday*, Justice Stevens describes the distinction as "broad and illogical," and adds:

> Had Congress intended this result, it could have stated simply that 'all State laws are pre-empted insofar as they relate to any self-insured employee plan.' There would then have been no need for the 'saving clause' to exempt state insurance laws from the pre-emption clause, or the 'deemer clause,' which the Court today reads as merely reinjecting into the scope of ERISA's pre-emption clause those same exempted state laws insofar as they relate to self-insured plans.

Holliday, — U.S. at —, 111 S. Ct. at 411 (Stevens, J., dissenting).

[3] Under 29 U.S.C. § 1132, ERISA plan participants or beneficiaries harmed by a lengthy delay in, or unreasonable denial of, benefits may bring a time-consuming and expensive action in court to recover no more than the benefits due under the plan. § 1132(a)(1)(B). The award of attorney's fees is possible, but solely within the discretion of the court. § 1132(g)(1).

preempt all state law that may be loosely defined as "relating to" employee benefit plans is "counterproductive to ERISA's objective of furthering, rather than debilitating, progressive employment law." Gregory, *The Scope of ERISA Preemption of State Law; A Study in Effective Federalism,* 48 U. Pitt. L. Rev. 427, 457 (1987).

Moreover, expansive preemption of state common law and statutes regulating the insurance industry upsets the equilibrium between the federal government and the states that Congress intended to preserve by enacting the saving clause, 29 U.S.C. §1144(b)(2)(A), thereby eviscerating this once-important provision. In *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985), the clause was initially given vitality by acknowledgment of the well-established rule that "[t]he presumption is against pre-emption, and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope." *Id.* at 741. The presumption against preemption is particularly strong with respect to those areas, such as insurance, "traditionally regarded as properly within the scope of state superintendence." *Florida Lime and Avocado Growers v. Paul,* 373 U.S. 132, 144 (1963); *Jones v. Rath Packing Co.,* 430 U.S. 519, 525 (1977).

In *Metropolitan Life,* while state-mandated policy inclusion of mental health coverage was related to the business of insurance and therefore within the scope of preemption, the saving clause directed that the law not be preempted. 471 U.S. at 739, 746-47. In so holding, the Court analyzed the legislative history of ERISA, and noted that the final version of the law included a preemption clause more broadly worded than those in the original versions submitted to the Conference Committee by the two houses of Congress. Rather than halting its analysis at that point, as it did in *Pilot Life,* 481 U.S. at 46, the Court pro-

ceeded to conclude that this expansion of the preemption clause "gave the insurance clause a much more significant role, *as a provision that saved an entire body of law from the sweeping general pre-emption clause.*" *Metropolitan Life,* 471 U.S. at 745 n.23 (emphasis added). The Court's holding thus refused to "impose any limitation on the saving clause beyong those Congress imposed in the clause itself." *Id.* at 746.

In contrast to the *Metropolitan Life* Court's careful deference to Congress' intent to balance the preemption and saving clauses, the *Pilot Life* opinion added a consideration that tips the balance of federalism inexorably away from the states by reducing the saving clause analysis to an empty exercise. The Court interpreted ERISA's legislative history to support the notion that Congress had intended that the statute's remedies be exclusive. This holding was drawn from the statements of several members of Congress to the effect that ERISA was meant to "preempt the field." 481 U.S. at 46. Congress' intent that ERISA provide exclusive remedies, however, was subordinate to its effort to provide greater protections to workers covered by pension and welfare benefit plans. When viewed in the light, the preemption clause should be given no more than equal consideration with the saving clause, which remains to preserve state regulation of insurance that is equally meant to safeguard the interests of workers.[4] Instead, as one commentator asserts, "the *Pilot Life* Court gutted the saving clause of meaning." Note, *Blind Faith, supra,* at 1382.

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[4] The Court correctly observed in *Metropolitan Life:* "While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time." 471 U.S. at 740. It seems that where ERISA is concerned, the Court has created an exception to this principle.

Refusing an interpretation of *Pilot Life* that would require the preemption of a California statute regulating the bad faith conduct of insurers, one court appropriately concluded that to do so "would rewrite the saving clause to read: 'Nothing in this subchapter *except section 1132* shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . .' The Supreme Court strongly indicated in *Metropolitan Life* that this is not the law." *Graves v. Blue Cross*, 688 F. Supp. 1405, 1412 (N.D. Cal. 1988) (emphasis in original). Unfortunately, this interpretation has now been rejected by *McClendon*. *Pilot Life* and *McClendon* thus seize from the states the ability to "deter[ ] insurance companies from exploiting insureds when they are most financially vulnerable." Note, *Blind Faith, supra*, at 1397.

By affirming *Pilot Life's* unfortunate mischaracterization of Congressional intent, the Supreme Court in *McClendon* takes another step away from the goals of federalism. States are no longer the laboratories of democracy[5] when it comes to protecting their consumers. States have been thwarted in their efforts to fill the federal void left in the regulation of insurance companies that provide benefit plans under ERISA. Gregory, *supra*, at 457. Ironically, this gap was initially created by the Congress in the McCarran-Ferguson Act, 15 U.S.C. § 1011, which entrusts to the States the regulation of "the business of insurance."

This federal court deprivation of state law protections stands in notable juxtaposition with the professed goal of some in Washington to return power to the states. The Texas courts and the Texas legislature are powerless

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[5] *See New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

to preserve the rights of workers covered by group benefit plans. Texans have little recourse but to petition their federal legislators to correct what has been an errant jurisprudential path. The time is long past for Congress to reconsider the expanse of ERISA and to resurrect the authority of the states to provide additional protections to their citizens.

LLOYD DOGGETT
Justice

Justices Mauzy and Gammage join in this concurring opinion.

OPINION DELIVERED: January 30, 1991

SUPPLEMENTAL APPENDIX C

THE SUPREME COURT OF TEXAS
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John T. Adams, Clerk

Received
Feb 4, 1991

February 1, 1991

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RE: Case No. C-8323
Style: JAMES C. CATHEY and BETTE CATHEY v. METROPOLITAN LIFE INSURANCE CO., DOW CHEMICAL CO., and MICHAEL MADDOLIN

Dear Counsel:

Enclosed is the judgment of the Supreme Court of Texas as said judgment appears in the Minutes of this Court. This is the judgment that will issue in mandate form to the lower court if no motion for rehearing is filed or if a filed motion for rehearing is overruled.

Sincerely,

John T. Adams, Clerk

by /s/ Peggy Littlefield
Peggy Littlefield,
Chief Deputy

SUPPLEMENTAL APPENDIX D

THE SUPREME COURT OF TEXAS

NO. C-8323

JAMES C. CATHEY and BETTE CATHEY Petitioners	§	FROM HARRIS COUNTY
v.	§	FIRST DISTRICT
METROPOLITAN LIFE INSURANCE CO., DOW CHEMICAL CO. and MICHAEL H. MADDOLIN Respondents	§	

JUDGMENT

THE SUPREME COURT OF TEXAS, having heard this cause on writ of error to the Court of Appeals for the First District, and having considered the appellate record and the argument of counsel, is of the opinion that the judgment of the court of appeals should be affirmed.

IT IS THEREFORE ORDERED, in accordance with the Court's opinion, that:

1) The judgment of the court of appeals, which affirmed the summary judgment rendered by the trial court for Metropolitan, Dow and Maddolin, is affirmed;

2) Metropolitan Life Insurance Co., Dow Chemical Co. and Michael H. Maddolin shall recover from James C. Cathey and Bette Cathey, who shall pay, the costs in this Court and in the court of appeals.

A copy of this judgment and of the Court's opinion is certified to the court of appeals and to the District Court of Harris County, Texas, for observance.

(Opinion of the Court delivered by Justice Gonzalez)
(Concurring Opinion by Justice Doggett joined by Justice Mauzy and Justice Gammage)

January 30, 1991

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